Course Description: Strategies for working with persons who abuse alcohol and other drugs and substances.

Course Learning Objectives: By the end of the term, students should be able to:
1. Describe social work practice with substance abusers and their significant others.
2. Identify the types of drugs and other substances typically used by abusers.
3. Specify the symptoms and the major physical/psychosocial consequences of selected types of substance use and abuse.
4. Discuss prominent theories concerning the etiology of different types of substance abuse.
5. Describe procedures used to screen for the presence of a drug.
6. Describe major public and private substance abuse prevention, education and treatment programs and services.
7. Discuss the strengths of the social worker's role in providing preventive, developmental, supportive and remedial services to substance abusers and their significant others.
8. Apply selected clinical theories, strategies and techniques when intervening with substance abusers and their significant others, in given case situations.
9. Describe ways in which the worker and client system share responsibility for ensuring the effectiveness and appropriateness of services for substance abusers and their significant others.
10. Demonstrate professional attitudes, behaviors and value orientations associated with ethical social work practice with substance abusers and their significant others.
11. Discuss the relative effectiveness of selected treatment and rehabilitation services and programs for improving the social functioning and reducing the stress experienced by substance abusers and their significant others from a systems perspective.
12. Identify the role of self-help, mutual aid, and other types of groups in providing social support to and empowering substance abusers and their significant others.
13. Utilize knowledge about diversity to effectively work with and on behalf of substance abusers and their significant others.
14. Analyze the relevance of course content for intervention with women, people of color, the aged, gays and lesbians, children and adolescents, the poor, and other special populations.
15. Demonstrate an ability to critically assess and improve services for substance abusers and their significant others.

Evaluation of Learning and Grading: Achievement of learning objectives will be measured as follows:
1. Treatment Center Visits: You are to visit a private for-profit and a public non-profit substance abuse treatment facility or two programs serving diverse populations. Compare and contrast the facilities, the treatment milieu, and the clientele of each. You should learn about the philosophy, population served, fees and other information you consider relevant. Conclude the write-up of your visit with your impressions of each facility. The instructor will provide an interview guide. If you have prior experience in a treatment facility, select other programs that cater to a different clientele than the one where you worked. Due Week 6 (20%)
2. **Client History/Assessment:** With approval of the field instructor, you must complete an alcohol and drug use history/assessment on a client seen in the student's field agency. In addition to those identified in the course texts, the instructor will supply examples of outlines for history taking and other resources for conducting the client assessment. Due Week 10 (20%)

Note: If you are not currently in a field placement or are in a placement where this assignment cannot be completed (i.e. hospice, Alzheimer’s care, etc.) you may do a retrospective history/assessment of an individual in recovery who you will meet at self-help meetings (see assignment 3).

3. **Self Help Meetings and Clinical Analysis: Part A:** You are to attend four (4) consecutive meetings of one of the following self help groups: Alcoholics Anonymous, Narcotics Anonymous, Women for Sobriety, Rational Recovery, Al-Anon (family members) or Adult Children of Alcoholics (ACOA), Narcotics Anonymous (NA) or Cocaine Anonymous (CA). You should keep a journal of your experiences documenting how the meetings were structured and conducted, the interaction of attendees, the apparent “impact” and other benefits of the meetings, and use of the group as a referral source. Document what you observe and analyze and integrate these into your paper (see part B).

**Part B:** You are to critically analyze the twelve steps of recovery adhered to in these self help groups and you must discuss the role self help groups play in abstinence and long term recovery. Citations from your course readings are expected.

Note: Part A - Journals can be hand written but must be legible. Part B - Paper must be double spaced typed 10-12 pages

Your journal will need to be turned in with your written assignment and should document meeting times and location and process of each meeting you attended. Due Week 14 (Part A=25% Part B=25%)

4. **Student Participation in Discussions and Evidence of Reading (10%).** All students are expected to prepare for and engage in an interactive and collaborative learning experience in the classroom. Therefore, it is expected that students will: (1) attend class, including the class meeting scheduled during exam week; (2) read assigned materials; (3) actively participate in course activities/exercises and in class discussions by offering examples, questions, concerns and opinions drawn from the field and readings; and, (4) complete all assignments.

A final course grade will be based upon the total number of points accumulated by a student on the above evaluations.

A = 90 - 100 points  B = 80 - 89 points  C = 70 - 79 points  D = 60 - 69 points  F = 59 points or less

**Required Texts:**

**Recommended Texts:**
Reserve articles, when listed on the Course Outline and Schedule that follows, are also required readings.

**Course Policies:** See the School of Social Work's Graduate Student Handbook and UCF’s The Golden Rule.

- Attendance is expected
- Three absences (excused or unexcused) will result in a one letter course grade reduction
- Late assignments will be reduced one letter grade per week

**Course Outline and Schedule**

**Unit 1: An Overview of Social Work Practice in the Field of Substance Abuse**

(Session 1 through 4)

**Session 1**  
Introduction and orientation to the course, review syllabus and assignments.  
Video: "Clean and Sober"* or "28 Days"  
Note: *This film received the Entertainment Industries Council PRISM Award for accurate depiction in the media of alcohol and/or drug problems.

**Session 2**  
Addiction as a disease: biological/genetic, psychosocial and socio-cultural contributors  
**Required:**
1. McNeece and DiNitto, op.cit., Chapter 1 "Definitions and Epidemiology of Alcoholism and Drug Addiction,"  
2. Johnson op.cit., Chapter 1 “Social Work and Substance Abuse Practice”; Ch. 3 “Models of Chemical Dependency”.  

**Recommended:**

**Session 3 & 4**  
Alcohol and drug experimentation, abuse, dependency and addiction  
Psychopharmacology of substance use, misuse and abuse.  
Polydrug addiction  

Video: Moyers on Addiction: The Hijacked Brain

**Required:**
1. Buelow and Buelow, op.cit., Chapter 1. “An Integrative Model of Chemical Dependence Treatment”.  
2. Johnson, op.cit., Chapter 2 “Pharmacology”  

**Unit 2: Assessment, Treatment and Rehabilitation of Substance Abusers and Their Significant Others**

(Session 5 through 11)

**Session 5**  
Diagnosing alcoholism and drug addiction  
Completing a drug and alcohol history  
Instruments to facilitate diagnosis: RAATE Assessment Guide, Substance Abuse Subtle Screening
Inventory (SASSI), Addiction Severity Index (ASI) and other screening protocols Differential diagnosis: Primary and secondary

**Required**
1. Buelow and Buelow Chapter 2, “Practical Decisions in Assessment and Referral”.
2. Johnson, op.cit. Chapter 5 “Macro Context of Substance Abuse Treatment. Chapter 7 “Introduction to Screening and Assessment”, Chapter 8 “Substance Abuse Assessment”.
   McNeece and DiNitto, op.cit., Chapter 5,“Screening, Diagnosis, Assessment and Referral.”

**Session 6** Confrontation and intervention with the chemically addicted
**Video: Lifestyles - Co-dependency and Intervention**
**Required**
1. Johnson, op.cit., Chapter 4 “The Art of Client Engagement”.

**Session 7 & 8** Clinical strategies in treating alcoholism and drug addiction
**Treatment approaches for the dually diagnosed patient**
**Using ASAM Placement criteria for treatment**
**Medications used in treating addictions**

**Video: Moyer on Addiction: Getting Help**

**Required**
1. Buelow and Buelow, Chapter 3 “Case Conceptualization, Treatment Planning, and Treatment”, Chapter 5 “Individual Treatment”.
4. Maintenance Treatment: History and Theory of Methadone Treatment

**Recommended**

**Session 9**
Chemical dependency and the family
Role redefinition and Co-dependence
Counseling children and adult children of alcoholics

**Video: When a Man Loves a Woman**

**Note:** This film received the Entertainment Industries Council PRISM Award for accurate depiction in the media of alcohol and/or drug problems.

**Required**
2. Buelow and Buelow, Chapter 6 “Family Dynamics and Treatment”, Chapter 7 “Children and Adult Children of Alcoholics and Other Drug Abusers”.
3. Johnson, op.cit., Chapter 5 “Understanding the Family”.
Session 10
The role of self help groups in treatment and recovery: Alcoholics Anonymous, Al Anon, Narcotics Anonymous, Women for Sobriety, Rational Recovery, Adult Children of Alcoholics (ACOA)

Video: 12 Steps to Recovery, Jack Trimpey on Rational Recovery

Required

Recommended

Session 11
Dynamics of relapse
Relapse prevention

Required
1. Buelow and Buelow, Chapter 4, "Maintenance, Relapse and Relapse Prevention

Unit 3 Selected Issues and Clinical Approaches for Effective Substance Abuse Intervention with Special Populations (Sessions 12 through 15)

Session 12 & 13
At-risk populations: Issues of culture, disabilities, gender and sexual preference in relation to alcohol and drug abuse HIV/AIDS and the substance abusing client

Required
1. Johnson, op.cit., Chapter 11 “Populations at Risk”.

Session 14
Substance abuse problems in the workplace
Employee assistance programs: organizational response – clinical interventions

Required
Session 15 Managed care and chemical dependency treatment
Prevention and social policy issues

Video: Moyers on Addiction: The Politics of Addiction

Required
3. NASW Monograph A Brief Look at Managed Care
A TWELVE STEP INTERPRETATION FOR WOMEN

1. We believe that we have choices and that our lives no longer need to be unmanageable.

2. We believe that a power within us and the support of those around us, can restore us to sanity.

3. We made a decision to turn our lives and our wills over to the care of ourselves and those in support of us without feeling selfish or guilty.

4. We made a searching and fearless inventory of our strengths and dreams.

5. We admit to ourselves and another human being the exact nature of all the “wrongs” we blamed upon ourselves.

6. We became entirely ready to let go of all our self-blame and self-shame, and understand the boundaries of our responsibility within the course of our lives.

7. We became willing to accept ourselves, love our individual and collective humanness and seek personal growth and fulfillment over perfection.

8. We made a list of all the persons who had harmed us; and became willing to acknowledge our hurt feelings and our anger, understanding that feelings need not be acted upon.

9. We made direct amends to ourselves for expecting perfection and continue in the acceptance of our self-love regardless of those who would deny us love.

10. We continue to take personal inventory and continue to take personal responsibility for self-love and expect the same of others.

11. We seek, through individual and collective awareness, to change and empower ourselves and distinguish between care, compassion, and trying to change others.

12. Having given ourselves permission to take care of our individual selves because we are deserving of love, we will carry this message to others and practice these principles in all our endeavors.
Since the Colonial times, Americans have sustained a prevalent and, tragically, a thoroughly destructive attitude toward alcoholism. This attitude can be recognized by the very obvious placement of a set of stockades in front of the ancient jail of Colonial Williamsburg, Virginia. The stockades, of course, represent the attitude that one could shame or punish and alcoholic into a sobriety or at least a more sociable intake of alcohol. The people of that time believed that the alcoholic was a person who lacked the moral fiber that was required to limit his amount of drinking. All he really had to do, they thought, was to use a little restraint or willpower and he could control his drinking. This type of “care and treatment” for the alcoholic gained a very small percentage of recoveries and therefore the practicing alcoholic developed a reputation as being, at the very least, uncooperative and, more often incorrigible.

The real tragedy of the false assumption that alcoholism is a moral question rather than a medical one was two-fold. First, few alcoholics were helped in their recovery. Secondly, by the very fact that there were so few recoveries, the assumption was perpetuated. It has been only in the last twenty years that society at large has begun to re-examine its views and attitudes towards alcoholism.

It was in 1956 that the American Medical Association declared alcoholism as “a disease that should be treated by a physician in a hospital setting when necessary”. This statement was a tremendous breakthrough because it was the precedent which showed that a prestigious medical association was taking a firm stand on accepting the disease concept of alcoholism. No longer was a person afflicted with the disease of alcoholism expected to have a spontaneous self-recovery simply because someone (physician, minister, judge or spouse) had diagnosed him as an alcoholic.

The same statement could be made about any other serious disease. For example, a person with a diagnosed heart condition is not expected to “cure himself” without some kind of outside help. The reason for the attitude that the heart patient needs other aid is that society has accepted the fact that a heart malfunction is a serious, if not vital, condition. In the same light, society is beginning to see that the “cure” for alcoholism is not just simply having the person cut down or control his drinking. Alcoholism is far more complex than that. As the American Medical Association states in their “Manual on Alcoholism”, which was printed in 1968, “The AMA identifies alcoholism as a complex disease with biological, psychological, and sociological components and recognizes medicine’s responsibility in the behalf of affected persons”.

How then can we more usefully define this complicated disease of alcoholism? Three words probably best describe this disease; the first being primary. By primary it is meant that alcoholism is a disease unto itself rather than a symptom of some greater social, emotional or physical problem. For years people thought that the excessive drinking was caused by an inability of the individual to cope with these larger problems. Therefore, if one could straighten out these larger problems, such as a disrupted family life, a disintegrating employment situation, or a worsening physical condition, then the drinking would straighten itself out. Social workers, employers, physicians, clergymen and spouses all attempted to rectify these specific problems, only to find that the harder they worked the more the alcoholic person drank. Therefore, if attention is directed solely toward the symptoms of the disease, the disease is held in check only temporarily before it regains its destructive power.

The same could be said for many other primary diseases, such as pneumonia. If one were only to wrap a blanket around a person suffering from this disease, or apply a cool compress to his feverish brown, the chances for this person’s recovery would be few. If, however, one were to perform these acts, plus providing the person with special antibiotics which attacked the microbes that caused these symptoms of chills and fever, the person would have a high chance for recovery. In other words treating only the symptoms of a
primary disease like pneumonia or alcoholism is, in most cases, inadequate. Thus the disease continues to worsen, which leads us to the next word that describes alcoholism.

The second word which is used to define the disease of alcoholism is **progressive**. By progressive it is meant that alcoholism leads a person to only two inevitable conclusions – either premature death or insanity. Death could come by various causes, such as an automobile accident, physical deterioration or suicide. Whatever the cause, the result is the same – years off the person’s life span. Dr. Thomas Briggs, Chief of the Medical Staff of St. John’s Hospital in St. Paul, Minnesota, and also the Medical Director of their alcoholism treatment center, states in a recent address to the Nebraska Methodist Hospital Medical Staff, “An Alcoholic untreated will die 14 years sooner than the average person”. If, however, a person lives and continues to drink, then he runs the risk of destroying enough brain cells to cause irreversible brain damage and thus create a necessity for permanent institutionalization.

A second important meaning of the word progressive is that the disease cannot remain at a status quo nor will it miraculously improve. Rather it always gets worse. The practicing alcoholic is very much like the terminal cancer patient. There are some days when the disease moves so slowly that it appears to be feeling like he will win his gallant battle for his life. Yet when the final day comes, it is obvious that the disease was progressing to its culmination in death. With alcoholism, the family tends to place its hopes and aspirations on the chance that “he will come to his senses and start drinking more sensibly”, or they deceive themselves through wishful thinking by noting, “Well, he isn’t drinking quite as badly as last month; maybe he is starting to come around”. In either case, the family is not willing to accept the reality of the progressive nature of the disease, and therefore they, in fact, are enabling the disease to progress to its tragic conclusion.

The third word which defines alcoholism is **chronic**. This word is often used erroneously to describe only the small five percent minority of alcoholics who inhabit skid row. In reality, this word could be more accurately used to describe all alcoholics, not just the down andouters. By the chronic disease, it is meant that the disease has no known cure. This statement sounds very foreboding and ominous, but there is hope. Although there is no known cure and therefore no such thing as an ex-alcoholic, there is a real chance for the alcoholic to lead a happy, fulfilling and meaningful life. In order to attain this life, however, he must be willing to adopt a new life style.

The chronic nature of alcoholism, like the chronic nature of diabetes, requires that the person adhere strictly to a different life regime in order to secure a healthy state of being. If the diabetic strays from his regime and begins to eat an overabundance of sugar, or if he ceases his daily injections of insulin, then the chronic nature of his disease becomes acute and his life is in grave danger. Likewise, if the alcoholic strays from his regime and begins trying to drink socially, then the chronic nature of the disease becomes acute and the progressive nature resumes, leading the alcoholic down the road to death or insanity.

**ONLY ANSWER IS ABSTINENCE!**

We are indebted to Vernon Johnson, The Johnson Institute, Minneapolis, Minn.
## ARE YOU AN ALCOHOLIC

Ask yourself the following questions and answer them as honestly as you can

<table>
<thead>
<tr>
<th></th>
<th>Yes</th>
<th>No</th>
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<tbody>
<tr>
<td>1.</td>
<td>Do you lose time from work due to drinking?</td>
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<td>2.</td>
<td>Is drinking making your home life unhappy?</td>
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<td>3.</td>
<td>Do you drink because you are shy with other people?</td>
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<td>4.</td>
<td>Is drinking affecting your reputation?</td>
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<td>5.</td>
<td>Have you ever felt remorse after drinking?</td>
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<td>6.</td>
<td>Have you gotten into financial difficulties as a result of drinking?</td>
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<td>7.</td>
<td>Do you turn to lower companions and an inferior environment when drinking?</td>
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<td>8.</td>
<td>Does your drinking make you careless of your family’s welfare?</td>
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<td>9.</td>
<td>Has your ambition decreased since drinking?</td>
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<td>10.</td>
<td>Do you crave a drink at a definite time daily?</td>
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<tr>
<td>11.</td>
<td>Do you want a drink the next morning?</td>
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<tr>
<td>12.</td>
<td>Does drinking cause you to have difficulty in sleeping?</td>
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<td>13.</td>
<td>Has your efficiency decreased since drinking?</td>
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<td>14.</td>
<td>Is drinking jeopardizing your job or business?</td>
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<tr>
<td>15.</td>
<td>Do you drink to escape from worries or trouble?</td>
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<tr>
<td>16.</td>
<td>Do you drink alone?</td>
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<tr>
<td>17.</td>
<td>Have you ever had a complete loss of memory as a result of drinking?</td>
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<tr>
<td>18.</td>
<td>Has your physician ever treated you for drinking?</td>
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<tr>
<td>19.</td>
<td>Do you drink to build up your self-confidence?</td>
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<tr>
<td>20.</td>
<td>Have you ever been to a hospital or institution on account of drinking?</td>
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</table>

If you have answered **yes** to any one of the questions, there is a definite warning that you may be alcoholic. If you have answered **yes** to any two, the chances are that you are an alcoholic. If you have answered **yes** to three or more, you are definitely alcoholic.

*(The above Test Questions are used by John Hopkins University Hospital, Baltimore, MD., in deciding whether or not a patient is alcoholic.)*

Are you an Alcoholic?
September 2000
V. **ATOD Assessment**

**A. On How Many Occasions Has The Youth**

1) **Smoked Cigarettes**

   Smoked cigarettes in youth’s lifetime:
   - _____ never tried
   - _____ 1 to 2 times
   - _____ 3 to 9 times
   - _____ 10 to 29 times
   - _____ 30 or more

   Smoked cigarettes in past six months:
   - _____ never tried
   - _____ 1 to 2 times
   - _____ 3 to 9 times
   - _____ 10 to 29 times
   - _____ 30 or more

   Age first smoked cigarettes:
   - _____ 11 or younger
   - _____ 12 to 14
   - _____ 15 to 17
   - _____ 18 years or older

2) **Used Smokeless Tobacco**

   Used smokeless tobacco in youth’s lifetime:
   - _____ never tried
   - _____ 1 to 2 times
   - _____ 3 to 9 times
   - _____ 10 to 29 times
   - _____ 30 or more

   Used smokeless tobacco in past six months:
   - _____ never tried
   - _____ 1 to 2 times
   - _____ 3 to 9 times
   - _____ 10 to 29 times
   - _____ 30 or more

   Age first used smokeless tobacco:
   - _____ 11 or younger
   - _____ 12 to 14
   - _____ 15 to 17
   - _____ 18 years or older

3) **Had Beer, Wine (other than for religious use) Or Wine Coolers**

   Had beer, wine or wine coolers in youth’s lifetime:
   - _____ never tried
   - _____ 1 to 2 times
   - _____ 3 to 9 times
   - _____ 10 to 29 times
   - _____ 30 or more

   Had beer, wine or wine coolers in past six months:
   - _____ never tried
   - _____ 1 to 2 times
   - _____ 3 to 9 times
   - _____ 10 to 29 times
   - _____ 30 or more

   Age first had beer, wine or wine coolers:
   - _____ 11 or younger
   - _____ 12 to 14
   - _____ 15 to 17
   - _____ 18 years or older

4) **Had Hard Liquor (such as rum, vodka or whisky)**

   Had hard liquor in youth’s lifetime:
   - _____ never tried
   - _____ 1 to 2 times
   - _____ 3 to 9 times
   - _____ 10 to 29 times
   - _____ 30 or more

   Had hard liquor past six months:
   - _____ never tried
   - _____ 1 to 2 times
   - _____ 3 to 9 times
   - _____ 10 to 29 times
   - _____ 30 or more

   Age first had hard liquor:
   - _____ 11 or younger
   - _____ 12 to 14
   - _____ 15 to 17
   - _____ 18 years or older
5) Had 5 or more servings of any alcohol on the same occasion

In youth’s lifetime:

_____ never tried
_____ 1 to 2 times
_____ 3 to 9 times
_____ 10 to 29 times
_____ 30 or more

During the past six months:

_____ never tried
_____ 1 to 2 times
_____ 3 to 9 times
_____ 10 to 29 times
_____ 30 or more

Age at first use:

_____ 11 or younger
_____ 12 to 14
_____ 15 to 17
_____ 18 years or older

6) Used Inhalants (glue, paint, rush, cleaning fluids, gasoline)

In youth’s lifetime:

_____ never tried
_____ 1 to 2 times
_____ 3 to 9 times
_____ 10 to 29 times
_____ 30 or more

During the past six months:

_____ never tried
_____ 1 to 2 times
_____ 3 to 9 times
_____ 10 to 29 times
_____ 30 or more

Age at first use:

_____ 11 or younger
_____ 12 to 14
_____ 15 to 17
_____ 18 years or older

7) Used Over the Counter Drugs (diet pills, No-Doz., caffeine) Above The Recommended Dosage:

Abused over-counter drugs in life

_____ never tried
_____ 1 to 2 times
_____ 3 to 9 times
_____ 10 to 29 times
_____ 30 or more

Abused over-counter drugs in past six months

_____ never tried
_____ 1 to 2 times
_____ 3 to 9 times
_____ 10 to 29 times
_____ 30 or more

Age first abused over-counter drugs

_____ never tried
_____ 1 to 2 times
_____ 3 to 9 times
_____ 10 to 29 times
_____ 30 or more
B. Used Illicit Drugs

1) Has the youth ever used illicit drugs? _____Yes _____No

<table>
<thead>
<tr>
<th>Number of occasions in the youth’s lifetime</th>
<th>Marijuana/Hashish</th>
<th>Cocaine (exclude use of crack)</th>
<th>Smoked Crack Cocaine (rock)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Never tried</td>
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<td>1 to 2 times</td>
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<tr>
<td>3 to 9 times</td>
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<td>10 to 29 times</td>
<td>10 to 29 times</td>
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<td>30 or more times</td>
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<thead>
<tr>
<th>Number of occasions during the past six months</th>
<th>Marijuana/Hashish</th>
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<th>Smoked Crack Cocaine (rock)</th>
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<td>3 to 9 times</td>
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<td>10 to 29 times</td>
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<td>30 or more times</td>
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<thead>
<tr>
<th>Age at first use</th>
<th>Marijuana/Hashish</th>
<th>Cocaine (exclude use of crack)</th>
<th>Smoked Crack Cocaine (rock)</th>
</tr>
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<tbody>
<tr>
<td>11 or younger</td>
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<td>12 to 14</td>
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<td>15 to 17</td>
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<tr>
<td>18 years or older</td>
<td>18 years or older</td>
<td>18 years or older</td>
<td>18 years or older</td>
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</table>

2) Has the youth ever been asked to sell drugs? _____Yes _____No

3) Has the youth ever sold drugs? _____Yes _____No

4) Has the youth ever taken:
   ____Yes ____No steroids?
   ____Yes ____No depressants (such as valium, Quaaludes)?
   ____Yes ____No hallucinogens (such as PCP, LSD, mescaline, Mushrooms, ecstasy)?
   ____Yes ____No stimulants (such as prescription diet pills, uppers, speed, ice)?
   ____Yes ____No narcotics (such as heroin/smack, codeine, morphine, dilaudid)?

5) Has the youth ever used:
   ____Yes ____No alcohol and marijuana on the same occasion?
   ____Yes ____No two or more drugs on the same occasion (exclude alcohol and tobacco)?
   ____Yes ____No a needle to inject cocaine, heroine, or other illicit drug?
C. How Was The Youth First Influenced To Use?

1) Alcohol
   ____Never tried
   ____Parent figure(s)
   ____Other household member
   ____Friends
   ____Through selling it
   ____Other

2) Drugs
   ____Never tried
   ____Parent figure(s)
   ____Other household member
   ____Friends
   ____Through selling it
   ____Other

D. Household Member’s Substance Use

<table>
<thead>
<tr>
<th></th>
<th>Mother Figure</th>
<th>Father Figure</th>
<th>Spouse/Partner</th>
<th>Other Significant Person</th>
</tr>
</thead>
<tbody>
<tr>
<td>1) Drug Use</td>
<td></td>
<td></td>
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Barriers to Women Seeking Treatment

- Male-oriented identification and treatment models.

- Perception and Beliefs
  - Women internalize stigmatization. Shame and guilt may discourage them from seeking treatment.
  - Women are willing to admit problems and seek help, but usually through medical channels.

- Social Characteristics
  - Female substance abusers likely to have primary responsibility for child care.
  - Female substance abusers likely to be involved with partners who use substances themselves or hide the women’s substance abuse.
  - Pressures not to enter treatment are greater for women.

- Environmental and Situation Characteristics
  - Female substance abusers are often without insurance coverage.
  - Types of services available may be inappropriate for women.
DESCRIPTION OF THE CHEMICALLY DEPENDENT FAMILY

Chemically dependent families, as do all families, seem to generate a particular system – what we might call a family life style – that is the unique product of that family’s strengths, weaknesses, and general characteristics. Understanding a family system helps explain the action and behavior of the family as a whole, as well as that of each of its members. This is especially true of families who have experienced chemical problems. In chemically dependent families recurring patterns emerge and seem to have general applicability. Families with chemical problems share similar dynamics, rules and behavior that characterize and shape their systems. Insight into these three areas should help explain many of the difficulties a chemically dependent family faces in the recovery process when the family is reaching for a new system, a new life style. Let us look at some of these dynamics, rules and behavior.

Dynamics
First are the dynamics (i.e. forces) that gives shape to the chemically dependent family’s rules and behavior. Perhaps the most significant dynamic deals with the family’s inability to get “separateness” from the chemical problem. Specifically, the entire family in its responses toward itself and the outside world revolves around the chemically addicted person whose life in turn revolves around chemicals. Most everything the family does is in response to the chemically dependent person’s behavior. On one hand, the addicted person cannot manage his own life, and yet on the other hand, his problem has such a great effect on the family that he ends up controlling the family’s life through the embarrassment, fear, frustration and unpredictability his problem creates.

From this dynamic, or force, comes additional problems. Most chemically dependent families experience ongoing feelings of tension, anxiety and hopelessness:

“What's going to happen next?”
“Will she make a fool out of herself again?”
“Are mom and dad going to fight tonight?”
“Will the boss catch on?”

All of these questions and hundreds more like them reflect the tension and anxiety a family feels about its chemical problem. Brief periods of sobriety or abstinence do little to lessen the tension. Anticipation of past behavior recurring can be as painful as experiencing the behavior. Like wise after years of repeated failure and misery, the family feels a sense of hopelessness that anything can or will be done. For the children, if they are old enough, it’s hanging on until “I can leave home”. For the spouse it’s “I’ve tried everything! Nothing can be done”.

In light of these dynamics, it is easy to see how another force weaves throughout the family fabric, namely the family’s total inability to communicate in healthy ways. As the chemical problem progresses, the family’s feelings of tension and hopelessness rise, along with its inability to get “separateness” from the problem, communication among the family members becomes rigid, strained and distorted. Most direct and honest communication has been driven underground in frustration. These various dynamics in turn establish a set of rules that a chemically dependent family lives by. For most suffering families a great deal of time passes before these rules are challenged or broken.

Rules
The unique thing about family rules, especially in chemically dependent families, is that the rules are stated directly. Implicit within the family is a set of rigid, harmful rules that govern the actions of the family, and that the family unknowingly accepts. One rule, that seems to apply universally, is that everyone in the family is required to be an enabler. Much has been said about how the non-chemically dependent spouse is an enabler, but the children in such a family are also required to obey this rule. Failure to do so can bring wrath and abuse and accusations of disloyalty and ingratitude.
Another common rule says that family members will not talk directly or realistically among themselves or with others about what’s really going on in the family. Everyone knows about the chemical problem and reacts emotionally to it, but few such families engage in direct, honest communication about it. To break this no-talk rule causes a negative reaction that most family members are either too sick or fearful to risk. There is also the rule that implies that someone or something is responsible for the chemical addiction, other than the chemically addicted person himself. Scapegoats such as bosses, shrewish wives, economic hardships and irresponsible children are sought and easily found. All members of the chemically dependent family play by this rule. What we have here is massive “sincere delusion” on the family-wide basis. In summary, these various rules produce a rigid family system where members are unable to solve their problems, and where they unknowingly perpetuate the chemical problem. This can be seen in the behavior these rules produce.

Behavior
If one rule demands that all members of the family be enablers, it follows that the family will display a wide range of enabling behavior: Wives calling the boss to report that the flu bug has hit the family again, children explaining to the bridge foursome that mother forgot about the card date and is visiting someone else, or the husband once again carrying his passed-out wife upstairs and carefully putting her to bed. These typify the kinds of enabling behavior chemically dependent families show. In addition, as the disease progresses, the family collectively and singly engages in more and more isolating behavior. Withdrawal from each other and avoiding contact by staying away from home or in one’s room is frequently seen. Contact with friends and social acquaintances either stops or is significantly reduced. This pattern of the family withdrawing from itself and from society is especially evident in the later stages of the disease. This isolationist behavior makes help for a sick family even more difficult to obtain.

Imbalance and distortion of family roles constitute another set of behavioral responses to the family sickness. Older daughters often totally assume a mother role to keep the family going. Wives, in response to their sick husbands, become financial managers, decision-makers, disciplinarians and job seekers. In other words, conventionally held roles or shared role responsibilities are parceled out in a way to maintain family survival, not family health!

In addition to this behavior is a whole series of inconsistent and irrational actions by all members of the family in response to the frustrations and hopelessness the family feels about its situation. Each member of the family has his or her own way of reacting to the chemical dependency. For example, on one day, the non-chemically addicted spouse might respond with the “silent treatment” as a way of showing frustration and anger. However, on another occasion that same person is seen emptying out half-filled bottles and having a full-blown rage. Children, too, manifest inconsistent and irrational reactions toward the problem. Angry threats of running away and tearful pleading to change behavior will often come from the same son or daughter in a short span of time. Again, we have a sick family coping with a chronic, progressive disease in unhealthy and confusing ways. What we now have is a family whose dynamics, rules and behavior are so shaped by chemical addiction that the family operates under a rigid, sick system that needs “family recovery” to break that system and begin positive growth together.

Description of the chemically dependent family
September 2000
**Definitions of Drug Testing Terms**

**Chain of custody** refers to the methodology of tracking specified materials or substances for the purpose of maintaining control and accountability from initial collection to final disposition for all such materials or substances and providing for accountability at each stage in handling, testing, and storing specimens and reporting test results.

**Confirmation test, confirmed test, or confirmed drug test** means a second analytical procedure used to identify the presence of a specific drug or metabolite in a specimen, which test must be different in scientific principle from that of the initial test procedure and must be capable of providing requisite specificity, sensitivity, and quantitative accuracy.

**Drug** means alcohol, including a distilled spirit, wine, a malt beverage, or an intoxicating liquor; an amphetamine; a cannabinoid; cocaine; phencyclidine (PCP); a hallucinogen; methaqualone; an opiate; a barbiturate; a benzodiazepine; a synthetic narcotic; a designer drug; or a metabolite of any of the substances listed in this paragraph. An employer may test an individual for any or all of such drugs.

**Drug rehabilitation program** means a service provider, established pursuant to s. 397.311(28), that provides confidential, timely, and expert identification, assessment, and resolution of employee drug abuse.

**Drug test or test** means any chemical, biological, or physical instrumental analysis administered, by a laboratory certified by the United States Department of Health and Human Services or licensed by the Agency for Health Care Administration, for the purpose of determining the presence or absence of a drug or its metabolites.

**Employee** means any person who works for salary, wages, or other remuneration for an employer.

**Employee assistance program** means an established program capable of providing expert assessment of employee personal concerns; confidential and timely identification services with regard to employee drug abuse; referrals of employees for appropriate diagnosis, treatment, and assistance; and follow up services for employees who participate in the program or require monitoring after returning to work. If, in addition to the above activities, an employee assistance program provides diagnostic and treatment services, these services shall in all cases be provided by service providers pursuant to s. 397.311(28).

(h) "Employer" means a person or entity that employs a person and that is covered by the Workers' Compensation Law.

**Initial drug test** means a sensitive, rapid, and reliable procedure to identify negative and presumptive positive specimens, using an immunoassay procedure or an equivalent, or a more accurate scientifically accepted method approved by the United States Food and Drug Administration or the Agency for Health Care Administration as such more accurate technology becomes available in a cost-effective form.

**Job applicant** means a person who has applied for a position with an employer and has been offered employment conditioned upon successfully passing a drug test, and may have begun work pending the results of the drug test. For a public employer, "job applicant" means only a person who has applied for a special-risk or safety-sensitive position.

**Medical review office or MRO** means a licensed physician, employed with or contracted with an employer, who has knowledge of substance abuse disorders, laboratory testing procedures, and chain of custody collection procedures; who verifies positive, confirmed test results; and who has the necessary medical training to interpret and evaluate an employee's positive test result in relation to the employee's medical history or any other relevant biomedical information.

**Prescription or nonprescription medication** means a drug or medication obtained pursuant to a prescription as defined by s. 893.02 or a medication that is authorized pursuant to federal or state law for general distribution and use without a prescription in the treatment of human diseases, ailments, or injuries.

(m) "Public employer" means any agency within state, county, or municipal government that employs individuals for a salary, wages, or other remuneration.

**Reasonable-suspicion drug testing** means drug testing based on a belief that an employee is using or has used drugs in violation of the employer's policy drawn from specific objective and articulable facts and reasonable inferences drawn from those facts in light of experience. Among other things, such facts and inferences may be based upon:
1. Observable phenomena while at work, such as direct observation of drug use or of the physical symptoms or manifestations of being under the influence of a drug.

2. Abnormal conduct or erratic behavior while at work or a significant deterioration in work performance.

3. A report of drug use, provided by a reliable and credible source.

4. Evidence that an individual has tampered with a drug test during his employment with the current employer.

5. Information that an employee has caused, contributed to, or been involved in an accident while at work.

6. Evidence that an employee has used, possessed, sold, solicited, or transferred drugs while working or while on the employer's premises or while operating the employer's vehicle, machinery, or equipment.

**Safety-sensitive position** means, with respect to a public employer, a position in which a drug impairment constitutes an immediate and direct threat to public health or safety, such as a position that requires the employee to carry a firearm, perform life-threatening procedures, work with confidential information or documents pertaining to criminal investigations, or work with controlled substances; a position subject to s. 110.1127; or a position in which a momentary lapse in attention could result in injury or death to another person.

**Special-risk position** means, with respect to a public employer, a position that is required to be filled by a person who is certified under chapter 633 or chapter 943.

**Specimen** means tissue, hair, or a product of the human body capable of revealing the presence of drugs or their metabolites, as approved by the United States Food and Drug Administration or the Agency for Health Care Administration.
## Differences Between the Disease and the Life Process Approach to Alcoholism

<table>
<thead>
<tr>
<th>Disease Model</th>
<th>Life Process Program</th>
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<tr>
<td>Alcoholism is inbred</td>
<td>Person uses alcohol permanent trait to cope with life</td>
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<tr>
<td>Everyone gets the same therapy</td>
<td>Treatment is tailored to individual</td>
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<tr>
<td>Person must accept he/she is alcoholic</td>
<td>Focus on problems, not labels</td>
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<tr>
<td>Therapy and goals are dictated to person</td>
<td>Person participates in therapy goals and plans</td>
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<tr>
<td>Person with drinking problem <em>must</em> be alcoholic</td>
<td>There are all kinds of drinking problems</td>
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<tr>
<td>Focus on drinking</td>
<td>Focus on coping</td>
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<tr>
<td>Abstinence is only resolution for a drinking problem</td>
<td>Improved control and successful relapse reduction sought as well as abstinence</td>
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<tr>
<td>Primary social supports are fellow alcoholics</td>
<td>Primary social supports: work, family, friends</td>
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<tr>
<td>Person must always think self as alcoholic</td>
<td>Person need not think of self as alcoholic</td>
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DO’S AND DON’TS FOR THE SPOUSES OF ALCOHOLICS

If you are the spouse of an alcoholic, probably your greatest hope is that someday your partner will be a reasonably health, happy, sober person. For years you may have directed your most concerted efforts toward this end.

With an inadequate understanding of the illness of alcoholism, the fight may have seemed a blind and unfair one – mere stabs in the dark – resulting in the despairing knowledge that many of your efforts have done more harm than good.

Don’t blame yourself for this. What you must realize is that both you and your spouse are victims of an insidious illness which breeds confusion, despair and anxiety. It isn’t a question of blame, but rather one of understanding.

Your solution lies in gaining knowledge of what you are up against. Once you have achieved this, you can come much closer to helping your spouse toward a quicker and more complete recovery. Even if this does not happen, you will be able to create for yourself and your family a happier and more normal home atmosphere.

The following suggestions based on present-day knowledge of alcoholism and the experience reported by the partner of recovering alcoholics will help you to develop a constructive program of action.

1. **Learn the facts about alcoholism.** You are a good deal more fortunate that the spouses of alcoholics in the past who could only guess what was wrong with their mates. There is much sound and unbiased information available today, and you should tap all the resources open to you.

2. **Development an attitude in keeping with the facts which you have earned.** Intellectual acceptance of the facts is essential; but unless your knowledge reaches the emotional level, it will do little good. You cannot accept your mate as a sick person in need of help if you still are blaming yourself for actions resulting from his illness. In this respect, try to remember, the alcoholic’s intense feeling of inadequacy and that attitudes of scorn, disgust or impatience exhibited toward him only push him into further escape.

3. **Avoid “home treatment methods”**. These are not only futile, but they are extremely harmful in many cases. **Preaching and lecturing** are useless ways of trying to help your mate, especially if he is intoxicated. He may already be suffering from feelings of guilt incomprehensible to the non-alcoholic. He has already told himself all and more than you could possible tell him. To remind him of his failures, his neglect of the family, his lack of social responsibility and social errors is more than he can take. For that reason, he hears as much as he can bear and simply shuts out the rest. The alcoholic’s thinking is mixed up whether he is sober or intoxicated. When you try to reason with him, or demand certain behavior of him, you only increase his need to lie, or force him to make promises he cannot possibly keep.

   While refraining from preaching or reasoning, try to guard against a “holier than thou” or martyr-like attitude. It is impossible to hide such an attitude from an alcoholic. His sensitivity is such that he judges other people’s attitudes toward him by small things much more than words, a fleeting expression, a tone of voice, or even the movement of your body. No matter what your words, if you feel skepticism, scorn, shame or suspicion, he will sense it and react. By the same token, if he hears kindliness and affection in your voice and actions, even when you have to say something difficult, he will hear it, and in time, come to believe in it or respond to it.
Another methods of the “home treatment” variety is the emotional appeal: “If you loved me”. Remember his drinking is compulsive. It cannot be controlled through will power. For the same reason, it is equally useless to try to coax him, extract promises from him, or threaten him. A word about the latter:

Don’t threaten unless you intend to carry out the threat. There may be times when you will have to take certain action for your own or the children’s protection, but idle threats only make the alcoholic feel you don’t mean what you say. Most often you don’t and are just hurt, desperate, or angry. If you do carry out a threat, be sure you think it through carefully and understand as fully as possible the implications in it for yourself as well as for the alcoholic. So often what was intended to punish or shock him only serves to hurt you.

Avoid the temptation to hide his liquor or pour it down the drain. No one act is a bigger waste of time and money. Besides pushing the alcoholic into a state of rage and desperation, you are only inviting him to find ways of getting more, which he will invariably do.

Don’t let your spouse persuade you to drink with him on grounds that he will drink less. He rarely does. As long as you condone drinking on his part, it is easier for him to put off doing something about his problem.

At best, all “home treatment” methods only serve to relieve your feelings, and usually drive your spouse farther away from you, and from getting the treatment he really needs.

4. Talk to someone besides friends and relatives. Most of these people are prejudices one way or another, and will often over persuade you to a course of action or an attitude which leaves you more hostile and confused than ever. People who understand the illness as well as your feelings about it can best help you find answers to the many problems you have as the spouse of an alcoholic.

5. Take a personal inventory of yourself in much the same manner as members of alcoholics anonymous do. Many spouses have found this helpful and report that the inventory revealed surprising personal problems which were not necessarily caused by their spouse’s drinking. The following statement made by one group of wives of AA members may challenge you as well, and give you comfort that you “are not the only one”.

“We spouses found, like everyone else, that we are afflicted with pride, self-pity, vanity and all the things that go to make up the self-centered person, and we were not above selfishness and dishonesty. As our mates began to apply the spiritual principles in their lives, we began to see the desirability of doing so too”.

It took much courage for the spouses, and much self-honesty, to face up to themselves, but they strongly recommend this action, painful though it may be at the time.

6. Try to develop a more positive, thoughtful attitude toward your spouse. He may never be the spouse you dreamed of, but as long as you go on trying to make him into the kind of person you want him to be, he will likely need to go on drinking. Stop treating him like a child, just because at times he acts like one. Don’t deny him some “mothering”, but at the same time, remember that he has many adult abilities which you have long since ceased to appreciate. Try to share the responsibilities you have taken over rather than handing them back to your spouse all at once. Begin to let believe in him and show him that you really need him, as you do, or you would long since have left him.

7. Don’t be jealous of the method of recovery your spouse has chosen. You may have a tendency to feel that his love for you and the children should have been sufficient incentive for seeking recovery; or
having had him dependent on you for so long a time, you may have felt left out when he turned for help
to persons outside the home. Remember that if he suffered from diabetes, you would not expect to be
his sole incentive for recovery, and neither would you feel jealous of the doctor who was helping him
back to health.

8. **Don’t expect an immediate 100% recovery.** As in other illnesses, there is going to be a period of
convalescence. There may be relapses, or dry drunks, and there will certainly be difficult days during
which old tensions and resentments flare up again. If you can accept these as a part of the illness, you
will find that it takes less out of you and will help to prevent or limit another drinking bout.

9. **Develop and maintain a healthy emotional atmosphere in your home.** Bickering, nagging and
tension make the home an unhappy place for you and the children as well as for the alcoholic. If you
are too absorbed with your own feelings, or your spouse’s drinking, the children’s relationship with you
is affected. If your attitude toward your mate is negative, he will take sides and become mixed up in his
thinking. They can often learn to accept, understand, or enjoy their drinking parent in spite of his or her
drinking. The atmosphere of the home affects every member, but it profoundly affects the alcoholic’s
recovery.

10. **Don’t try to protect your spouse against alcohol.** This is one of the quickest ways to push him into a
relapse. If you warn other people not to serve him drinks, you will be stirring up his old feelings of
resentment and inadequacy all over again. He must still live in a world where alcohol is served, and he
must learn on his own how to say “no” gracefully. By the same token, don’t refer to alcohol and his old
drinking habits unless he does. If he seems to want to discuss the subject, do so as naturally and
intelligently as you can.

**DON’T BE DISCOURAGED BY THE MISTAKES YOU MAKE!!!**

*Do’s and don’ts for the spouses of alcoholics*

*September 2000*
DRINKING QUESTIONNAIRE

1. Do you occasionally drink heavily after a disappointment, a quarrel, or when the boss gives you a hard time?
2. When you have trouble or feel under pressure, do you always drink more heavily than usual?
3. Have you noticed that you are able to handle more liquor than you did when you were first drinking?
4. Did you ever wake up on the “morning after” and discover that you could not remember part of the evening before, even though your friends tell you that you did not “pass out”?
5. When drinking with other people, do you try to have a few extra drinks when others will not know it?
6. Are there certain occasions when you feel uncomfortable if alcohol is not available?
7. Have you recently noticed that when you begin drinking you are in more of a hurry to get the first drink than you used to be?
8. Do you sometimes feel a little guilty about your drinking?
9. Are you secretly irritated when your family or friends discuss your drinking?
10. Have you recently noticed an increase in the frequency of your memory “blackouts”?
11. Do you often find that you wish to continue drinking after your friends say that they have had enough?
12. Do you usually have a reason for the occasions when you drink heavily?
13. When you are sober, do you often regret things you have done or said while drinking?
14. Have you tried switching brands or following different plans for controlling your drinking?
15. Have you often failed to keep the promises you have made to yourself about controlling or cutting down on your drinking?
16. Have you ever tried to control your drinking by making a change in jobs, or moving to a new location?
17. Do you try to avoid family or close friends while you are drinking?
18. Are you having an increasing number of financial and work problems?
19. Do more people seem to be treating you unfairly without good reason?
20. Do you eat very little or irregularly when you are drinking?
21. Do you sometimes have the “shakes” in the morning and find that it helps to have a little drink?
22. Have you recently noticed that you cannot drink as much as you once did?
23. Do you sometimes stay drunk for several days at a time?
24. Do you sometimes feel very depressed and wonder whether life is worth living?
25. Sometimes after periods of drinking, do you see or hear things that aren’t there?
26. Do you get terribly frightened after you have been drinking heavily?

Those who answer “yes” to any of the questions, says NCA’s medical director, Dr. Frank Seixas, may have some of the symptoms of alcoholism. Taking the questionnaire an important step further, “yes” answers to several of the questions indicate these stages of alcoholism: Questions 1 to 8 – early stage; questions 9 to 21 – middle stage; questions 22 to 26 - the beginning of the final stage.

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Florida’s Workers’ Compensation Drug-Free Workplace Program

Florida’s Workers’ Compensation Law allows employers who adopt the Law’s drug-free workplace program to receive numerous benefits. For example, employers who adopt such a program may be eligible to receive a discount on their workers’ compensation premiums and may improve their experience modification factor. Additionally, employees who test positive for drugs or alcohol at the time of the accident may lose workers’ compensation medical and indemnity benefits. Employees who test positive may also be disciplined and discharged for cause.

To obtain these benefits, an employer’s drug-free workplace program must comply with the program’s requirements. One time, prior to testing, an employer must give all employees and job applicants a written policy statement regarding the drug-free workplace program. An employer that does not have a drug-testing program must ensure that at least sixty days elapse between the notice and the beginning of actual drug testing. An employer having a drug-testing program in place prior to July 1, 1990, is not required to provide the 60-day notice period. An employer must include notice of drug testing on vacancy announcements for positions for which drug testing is required. A notice of the employer’s drug testing policy must also be posted in an appropriate and conspicuous location on the employer’s premises, and copies of the policy must be made available for inspection by the employees or job applicants. The drug testing policy or procedure must be applied equally to all employee classifications where the employee is subject to workers’ compensation coverage.

An employer who adopts a drug-free workplace program must conduct four types of drug tests. First, an employer must require job applicants to submit to a drug test and may use a refusal to submit to a drug test or a positive confirmed drug test as a basis for refusing to hire a job applicant. For a public employer, a job applicant means only a person who has applied for a special-risk or safety-sensitive position. Second, an employer must require an employee to submit to reasonable-suspicion drug testing. Third, an employer must require an employee to submit to a drug test if the test is conducted as part of a routinely scheduled fitness-for-duty examination. Fourth, if the employee in the course of employment enters an employee assistance program for drug-related problems, or a drug rehabilitation program, the employer must require the employee to submit to a drug test as a follow-up to such a program, unless the employee voluntarily entered the program.

Within five working days after receipt of a positive confirmed test result, an employer must inform the employee or job applicant in writing of the positive test result. Within five working days after receiving notice of a positive confirmed test result, the employee or job applicant may submit information to the employer explaining or contesting the test result, and explaining why the test result does not constitute a violation of the employer’s policy. If the employee’s or job applicant’s explanation or challenge of the positive test result is unsatisfactory to the employer, a written explanation as to why the explanation is unsatisfactory, along with the report of the positive result, must be provided to the employee or job applicant. If an initial drug test is negative, the employer may in its sole discretion seek a confirmation test.
IMPLEMENTING A DRUG-FREE WORKPLACE POLICY

Step One

Develop policy, including making sure a list of counselors/rehabilitation programs are available in Human Resources Department for employee referral, identify drugs to be tested for, determine how company will handle positive drug-test results on current employees, and determine how company will handle employees who self-identify.

Step Two

Identify drug-testing laboratory and medical review officer.

Step Three

Have policy reviewed by attorney and by workers’ compensation carrier to determine compliance with Florida Drug-Free Workplace Act to receive 5% discount on workers’ compensation premiums.

Step Four

Distribute and explain policy to supervisors before distributing to employees.

Step Five

Distribute policy to employees (60-days’ notice before effective date) and hold meetings to educate employees.

Step Six

Ensure Drug-Free Workplace Policy designation is indicated in all job advertisements and is posted where applicants apply for jobs.

Step Seven

Ensure policy is distributed to job applicants prior to pre-employment drug screening.

Step Eight

Ensure policy statement is included in employee handbook (referring to formal policy distributed separately).

Step Nine

After 60 days, ensure policy is distributed to employees prior to any subsequent drug test.
EMPLOYEE ASSISTANCE PROGRAM POLICY STATEMENT

PURPOSE

This document states the policy of (Name of Client Organization) regarding employee alcohol, drug, or emotional/personal problems, which result in deteriorating employee work performance, conduct, attendance or reliability. Further, this policy outlines the provisions of (Name of Client Organization) employee assistance program (EAP) developed to address such employee problems.

DEFINITIONS

For the purposes of this Policy Statement, terms pertinent to its use and understanding are defined as follows:

1. Alcohol Abuse - a treatable problem in which the employee's work performance or conduct may be impaired as a direct result of the use of alcohol.

2. Drug Abuse - a treatable problem in which the employee's work performance or conduct may be impaired as a direct result of use of legal or illegal drugs.

3. Emotional/Personal Problems - personal problems, which may impair job performance. Such problems include depression, anxiety, stress, psychiatric illnesses, and those stemming from the alcohol or drug abuse or emotional problems of another person, such as a spouse, a supervisor, or a co-worker. Such problems can also stem from working conditions or the nature of the job itself.

4. Community Resources - agencies and individual practitioners, accessible to the EAP's client population, including but not limited to: hospitals and other in-patient treatment facilities, clinics, and other out-patient treatment facilities, family counseling services, financial counseling services, self-help groups for medical/personal/emotional problems.

5. Third Party Payments - payments made by an employee's insurance company to community resources that cover, in full or in part, the costs of treatment.

6. Treatment - assistance that is offered by community resources.

7. EAP Counseling - professional counseling provided by the EAP staff or under their supervision. EAP counseling is short-term and crisis-oriented. It includes assessment, information, short-term counseling and when appropriate, outside referral and follow-up.

8. Self-Referral - the voluntary use of the EAP confidential basis for employees who suspect that they may have alcohol, drug abuse, emotional, or other personal problems.

9. Supervisory Referral - the referral of an employee with deteriorating job performance or conduct problems to the EAP by a supervisor.

10. Supervisory Consultation - discussions between a supervisor and EAP staff member, the purposes of which are to discuss a potential supervisory referral, to assist a supervisor in making a referral, to confer during the course of counseling, or to follow-up when counseling is terminated.

11. Outside Referral - the referral of an employee to one or more community resources based on a careful assessment made by an EAP counselor.

12. Consent Form - this form is sometimes called "Consent for Release of Confidential Information" or a "Form of Consent".
EAP POLICY GUIDELINES

1. The purpose of counseling in the Employee assistance program (EAP) is to assist employees with problems, which impact adversely upon work performance or conduct. When these problems are effectively confronted and treated, the employees are expected to become healthier, better-adjusted individuals and are likely to perform more productively in their jobs. Employees, who suspect they have an alcohol, drug abuse, emotional, or other personal problem, whether or not it currently affects their work, are encouraged to use the EAP voluntarily on a confidential basis.

2. Employees who voluntarily seek out the services of the EAP must arrange to do so on their own time (e.g., lunch period, vacation or personal leave, before or after their duty hours based on the availability of a counselor. Employees who are referred to community resources for treatment must request approved leave for these sessions if they occur during the regular workday.

3. It is the supervisor's responsibility to monitor and make explicit to employees expectations about work performance. When an employee's work performance is inadequate, the supervisor must advise the employee of the deficiency and allow an opportunity to correct the problem. Early confrontation of inadequate work performance will generally be most helpful in returning employees to full productivity. When the supervisor determines that ordinary supervisory methods are not bringing about improvement in an employee's performance, the supervisor should:

   a. Discuss the situation with an EAP counselor. At these supervisory consultations, the counselor acquires a good understanding of the employee's performance problems and assists the supervisor in referring the employee, if appropriate. The supervisor may also wish to discuss the situation with an appropriate individual in the department of human resources.

   b. Offer the employee referral to the EAP. The supervisory referral to the EAP should be written as well as oral. The written referral is the supervisor's record that an offer of counseling has been made to the employee. The counselor assists the supervisor in preparing this memorandum during supervisory training and consultation sessions. The written referral should only: (1) document the inadequate work performance; (2) specify that neither the documentation nor the referral to the EAP constitutes a disciplinary action; (3) indicate that the supervisor had spoken to an EAP counselor, and (4) offer EAP services to the employee. This memorandum must not be placed in the employee's official Personnel file. If the memorandum is part of a system of records of the supervisor, The Privacy Act prevents its disclosure beyond the EAP without the employee's consent. If an adverse action is taken against an employee who received a written offer of EAP assistance and who subsequently denies having received it, the written referral may become part of the adverse action file as the supervisor's record of compliance.

   c. Employees who are formally referred by their supervisor to the EAP are authorized to attend the first session with the counselor on regular paid time. Thereafter, employees must make arrangements to see the counselor on the same basis as employees who are self-referred.

   d. Allow a reasonable period, as determined jointly by the supervisor and the counselor, for the employee's work performance to improve.

   e. Consult with Human Resources in taking administrative or disciplinary actions if acceptable job performance does not result after the decided-upon period.

4. Like poor performance, an employee's misconduct may be caused or aggravated by alcohol abuse, drug abuse, and emotional or personal problems. Whenever possible, supervisors should consider referring
such employees to the EAP prior to or concurrent with proposed disciplinary actions. An offer of assistance, even one made concurrently with the proposed disciplinary action, does not protect the employee against such action. When a supervisor has good reason to believe that an employee’s misconduct is directed towards, or potentially harmful to, others or to property, the supervisor's first obligation is to those persons or properties and then to the employee. As noted above, the supervisor should first discuss the situation with an EAP counselor and then orally and in writing offer the employee referral to the EAP program.

5. EAP involvement may negate the need for disability or provide assistance to employees who do not qualify for disability. Before an employee undergoes medical examination procedures dealing with disability for a psychiatric disease, a supervisor should consider referring that employee to the EAP. Use of the EAP shall not in itself affect eligibility for disability, neither confirming such eligibility nor jeopardizing it.

6. Regardless of the nature of the referral, the EAP counselor will not disclose any information about a participating employee to the employee's supervisor without the employee's written consent. The EAP counselor will discuss the Consent Form, which the employee has the option to sign, but is not required to do so. Only if the employee signs the form, may the EAP counselor inform the supervisor whether the employee is making progress. If the employee chooses not to sign the Consent Form, the EAP counselor may not disclose any information to the supervisor, except whether or not the employee made or kept appointments during duty hours. The Consent Form may also be used when a counselor refers an employee to a community resource. In this instance, the signed consent allows the community resource to provide to the EAP counselor, not the supervisor, information about an employee’s program. (See Exhibit A)

7. Whenever outside referral to a community agency or practitioner is deemed advisable for an employee, the EAP will refer the employee to appropriate treatment services. The EAP will attempt to assure that the costs of such treatment are kept within the employee's financial means by utilizing third-party payments, community resources which use sliding fee scales, and self-help groups to the extent possible.

8. Counseling records and information from employee visits to the EAP will be kept, as all medical records, in a confidential manner, in accordance with Sections 122 and 303 of P.L. 93-282 and implementing regulations; the Privacy Act of 1974; and 42 CFR, Part 2, "Confidentiality of Alcohol and Drug Abuse Patient Records".
EMPLOYEE ASSISTANCE FACT SHEET

Definition - Employee Assistance Program (EAP)
The Employee assistance professionals association (EAPA) defines an EAP as a worksite-based program
designed to assist (1) work organizations in addressing productivity issues and (2) employee clients in
identifying and resolving personal concerns (including, but not limited to, health, marital, family financial,
alcohol, drug, legal, emotional, stress, or other personal issues) which may affect job performance.

A few statistics (according to 1996 EAPA survey of member EA professionals):
♦ Approximately 80% of Fortune 500 companies have EAP in place.
♦ Problems seen most frequently include family crisis (25%); stress (23%); depression (21%); alcoholism
  (14%); workplace/job-conflict (9%); substance abuse (2%).

Employee Assistance Program Services or EAP services are designed to address work organization
productivity issues and employee client problems affecting job performance and ability to perform on the job.
These services may include, but are not limited to, the following:

1. Consultation with, training of, and assistance to work organization leadership (managers, supervisors, an
union stewards) seeking to manage the troubled employee, enhance the work environment, and improve
employee job performances, and outreach to and education of employees and their family members
about availability of EAP services;
2. Confidential and timely problem identification/assessment services for employee clients with personal
concerns that may affect job performance;
3. Use of constructive confrontation, motivation, and short-term intervention with employee clients to
address problems that affect job performance.
4. Referral of employee clients for diagnosis, treatment, and assistance, plus case monitoring and follow up
services;
5. Consultation to work organizations in establishing and maintaining effective relations with treatment and
other service providers, and in managing provider contracts;
6. Consultation to work organizations to encourage availability of and employee access to health benefits
covering medical and behavioral problems, including, but not limited to, alcoholism, drug abuse, and
mental and emotional disorders; and
7. Identification of the effects of EAP services on the work organization and individual job performance.

Costs of worksite Behavioral Health Problems
1. Reduced productivity as high as $100 billion (Drug Abuse in the Workplace: Consensus Summary,
National institute on Drug Abuse, 1986).
2. 40% of industrial fatalities and 47% of industrial injuries are linked to alcohol consumption and alcoholism
(Occupational Medicine, Vol. 4, No. 2, 1989).
3. 36% of all employee thefts in a study of 102 companies were directly related to drug problems of abusing
employees (Hoffman-LaRoche, Inc., October 1989).
4. Drug reliant employees incur 300% higher medical costs and benefits compared to healthy co-workers
(U.S> Chamber of Commerce survey found in Workers at Risk: Drugs and Alcohol on the Job. U.S.
Department of Labor, 1990).
5. Nearly 25% of a drug dependent employee’s salary is lost through increased use of medial benefits, poor
attendance low productivity (“Managerial Responses to drug abuse in the Workplace,” Journal of Small
Business Management, April 1989).
6. Approximately 25% of working parents worry about their children during the day (Balancing Job and
Homelife Study: Summary of Findings, Boston University School of Social Work, 1986).
7. Stress disability cases rose from 6% in 1982 to 13% in 1990.
8. Using $50 as the baseline for monthly costs of healthcare by the normal citizen, a report prepared for the Commission on Model State Drug Laws found these startling healthcare usage statistics:
   ♦ The early alcoholic – ten years before his or her crisis state – is spending double that amount.
   ♦ By the time the alcoholic reached crisis, that cost is 10 to 12 times as high.
   ♦ Alcoholics are susceptible to a variety of illnesses and occupy 25 to 40 percent of hospital beds.
   ♦ Physicians generally do not identify the underlying problem and instead treat the presenting problem.
   ♦ Currently 15% of the healthcare budget is consumed by these mostly “secondary effects” costs. When “collateral cost offsets” (family) are added to that amount, healthcare costs are no longer contained.

Findings in Support of EAPs
1. For every dollar invested in a Drug Free Workplace program with an EAP as an integral part, employers generally save anywhere from $5 to $15.

2. Use of EAP’s have been shown to result in:
   ♦ 66% decline in absenteeism after alcohol abusers have been identified and treated (Hazelden Foundation, 1988);
   ♦ 33% decline utilization of sickness benefits; 65% decline in work-related accidents; 30% decline in workers’ compensation claims (American Management Magazine, November, 1985)
   ♦ A McDonnell Douglas Corporation independent study in 1989 found a 35% reduction of overall healthcare costs;
   ♦ 28% savings on mental health benefits (Journal of Health Care Benefits, January/February 1992)

3. A study prepared for the Model State Drug Laws shows
   ♦ Addiction treatment represents just one percent of total healthcare costs in the U.S. compared to 15% when untreated.
   ♦ Identification, treatment, and follow-up can bring the alcoholic to near normal healthcare usage ($50 baseline) within one to two years-and that low level endures for at least seven years.
   ♦ Five years after treatment, healthcare costs for the family of the alcoholic can fall below the baseline.

4. Specific success stories include:
   ♦ General Motors corporation drug-free workplace program saves the company $3,700 for each employee enrolled in the program.
   ♦ Philadelphia Police Department employees undergoing treatment reduced their number of sick days by an average of 38% and their injuries by 62%.
   ♦ Oldsmobile’s Lansing, Michigan plant saw healthcare costs decrease by 29% and disciplinary problems decreased by 63.
**Employee Defense Strategies or Traps**

Employees can be expected to feel threatened and use various defenses to protect themselves. Below we list and describe some of these defenses and recommended counter-moves.

<table>
<thead>
<tr>
<th>Defense or Trap</th>
<th>Description of Example</th>
<th>Counter-Move</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Excuses &amp; Sympathy</strong></td>
<td>Employee will have a good reason for everything that happens. &quot;You'd have the same troubles if you had a wife like mine.&quot;</td>
<td>&quot;You may have problems at home. I am concerned about your performance, and my data here says that you are not doing your job.&quot; Referral.</td>
</tr>
<tr>
<td><strong>Apology and Promises</strong></td>
<td>&quot;I’m really sorry. You know that! I’ll never do it again.&quot;</td>
<td>&quot;I appreciate your apology but what you do is serious.&quot;</td>
</tr>
<tr>
<td><strong>Switching</strong></td>
<td>&quot;I know about that, but look what a good job I’ve done on that Sentron job!&quot;</td>
<td>You did do well on the Sentron. I want good work on all jobs. You have had more problem jobs than successful ones lately. Look at the record.&quot;</td>
</tr>
<tr>
<td><strong>Anger</strong></td>
<td>&quot;Damn it!! One mistake and the roof falls in – after 15 years of killing myself for this place.&quot;</td>
<td>&quot;I expect you to listen to me. Getting angry won’t help anyone, especially you. I’m concerned about your performance. And I’m not talking about one mistake. Look at the record.”</td>
</tr>
<tr>
<td><strong>Tears and Helpless</strong></td>
<td>&quot;I don’t know what to do. I’ll never get out of this mess.&quot;</td>
<td>&quot;I appreciate your feelings about this. I want you to know that I want to help, which is why I set up this meeting. You have been a valuable part of our organization. I want to tell you about the Employee Assistance Program”</td>
</tr>
<tr>
<td><strong>Self-Pity</strong></td>
<td>&quot;I knew this would happen. I’ve never been able to do anything right.&quot;</td>
<td>&quot;I wouldn’t be taking this time to talk to you if I didn’t have confidence in you. So let’s move on to talk about what can be done to help. You know, our Employee Assistance Program would may be able to help you.”</td>
</tr>
<tr>
<td><strong>Innocence and Blaming</strong></td>
<td>&quot;It’s not my fault. Joe let me down. I don’t get any help around here.&quot;</td>
<td>&quot;I’ve checked into this in detail (point to records). We need to start with what we can do to correct the problem.”</td>
</tr>
<tr>
<td><strong>Hopelessness</strong></td>
<td>&quot;I may as well quit now.&quot;</td>
<td>&quot;Be realistic. You have done excellent work before this. I want more of that from you, which is why I set up this meeting in the first place.”</td>
</tr>
<tr>
<td><strong>Friendliness and Seduction</strong></td>
<td>&quot;Now Bill…you know we’ve been through this before and we worked it out together. Let’s get together after work and figure this out where we can be more comfortable.”</td>
<td>&quot;I know we’ve been through this before and this time things will be different, because I’ve done all I can to work this out on the job. I think something else is bothering you and I want you to talk with an EAP counselor.”</td>
</tr>
</tbody>
</table>
GENDER DIFFERENCES

PROBLEMS AND CONSEQUENCES RESULTING FROM SUBSTANCE USE

○ WOMEN: Personal and Self-destructive
  ▪ Health problems.
  ▪ Psychological/emotional problems.
  ▪ Relationship and family problems (being rejected or abandoned).
  ▪ Threats of having children taken away.

○ MEN: Societal and other Destructive
  ▪ Legal problems due to criminal activities.
  ▪ Employment problems due to absenteeism or poor performance.
  ▪ Relationship and family problems (neglecting, abusing, or abandoning partner and family).

CONTEXT OF SUBSTANCE USE

<table>
<thead>
<tr>
<th>MEN</th>
<th>WOMEN</th>
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<tbody>
<tr>
<td>Introduced to drugs by male peers.</td>
<td>Introduced to drugs by spouse, boyfriend, partner.</td>
</tr>
<tr>
<td>Buy own drugs from people they do not know well.</td>
<td>Have drugs supplied to them by male partner or male physician.</td>
</tr>
<tr>
<td>US IV drugs alone and inject drugs themselves.</td>
<td>Use drugs with male partner who has prepared drugs for use and dispenses or injects them for the women.</td>
</tr>
<tr>
<td>Control access to and distribution of drugs.</td>
<td>Depend on partner to provide drugs.</td>
</tr>
<tr>
<td>Usually drink in public places, alone or with partner.</td>
<td>Mole likely to drink at home or alone with partner.</td>
</tr>
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</table>
GLOSSARY OF EAP TERMS

**Affiliate Model EAP**: An EAP in which a vendor subcontracts with local professionals rather than using salaried staff.

**Alcohol Abuse**: Consumption of alcohol in a manner and degree that impairs functioning and harms or endangers the health, safety and well-being of the user or those with whom the user comes in contact.

**Assessment Diagnosis**: An evaluation in which professional expertise and skills are exercised to collect and analyze data in order to understand and describe the nature of service needs of an individual, family, or group. Assessment, as in needs assessment, is also used to determine priorities of program planning and service development for the organization as a whole.

**Assessment and Referral EAP Model**: An EAP which has as its primary focus employee education, supervisory training, crisis intervention, the assessment of presenting problems of the employee and/or dependent(s), the referral of individuals who have problems to appropriate resources and systematic follow up.

**Brief Treatment**: A form of therapy which focuses on the essential issue for a short period of time that is worked on with the counselor and the client in a goal directed plan.

**Certified Employee Assistance Professional (CEAP)**: Established by EAPA in 1986, the CEAP provides a means to ensure that practitioners, regardless of background, possess a standard level of knowledge necessary for employee assistance programming. The program grants certified status to practitioners who pass a written examination. In order to qualify to take the examination, a practitioner depending upon educational level must possess two to three years experience in EAP programming, including a minimum of 2,000 to 3,000 hours devoted to employee assistance programming.

**Chemical Dependency**: Physiological and psychological dependence on a chemical, such as alcohol, tobacco, and narcotics, which results in increased tolerance and in withdrawal symptoms when the chemical is removed.

**Critical Incident Stress Debriefing (CISD)**: A method of EAP intervention that is implemented after a crisis to handle individual and group reactions to the initial shock and trauma. May be included as part of a comprehensive, integrative, multi-component crisis intervention system and applied to a wide variety of community and occupational settings.

**Detoxification**: The process by which drugs or other harmful substances are removed from a person’s body for a time period sufficient to restore adequate physiological and psychosocial functioning.

**Drug Abuse**: Misusing a chemical substance in a manner that is detrimental to an individual’s physical or mental well-being and or safety and well being of others.

**Drug Addiction**: A state of physiological dependence that results from the abuse of chemical substances. In the absence of the substance, an individual experiences systems of withdrawal.

**Drug Testing Policies**: Company procedure outlined for the collection of urine specimen and the laboratory analysis of such and the reporting to appropriate designated medical personnel before informing the employee.
**EAP – Employee Assistance Plan/Program:** Assessment, information, referral, short-term counseling, and other employment-related services provided under a contract or arrangement with an employer, union, or organization.

**Employee Education:** Regular scheduled programs by the EAP providing information on a variety of subjects.

**Impairment:** A loss of abnormality in physiological, psychological, or mental structure or functioning, such as paralysis of a limb, mental retardation, or blindness.

**In-house Program:** An EAP in which all staff members are employed by the company the program serves.

**Internal Program:** Any employee assistance program whose EAP counselors or employee assistance clinicians are employed by the sponsoring organization.

**Out-of house EAP:** An EAP in which a firm is contracted to provide the EAP staff and services.

**Return To Work Agreement:** Formal document signed by an employee that delineates specific conditions for being able to return to work as drug testing, and as attendance at an EAP

**SAP:** Substance Abuse Professional designated in the Department of Transportation regulation with specific responsibilities.

**Short-Term Counseling EAP Model:** an EAP that in addition to the requirements for the Assessment and Referral Model provides short-term solution focused counseling sessions to the majority of the EAP contracts. These programs must offer no less than three or no more than twelve counseling sessions to qualify for this designation. To qualify at one session, the session length should be a minimum of 45 minutes.

**Supervisory Training:** An essential ingredient of an EAP that educates managers as to what is an EAP, how to refer and consultation availability.
INTERVENTION AND THE ALCOHOLIC

Early intervention is a must and it produces a great likelihood of recovery.

In intervening with the disease of alcoholism there are three basic factors that must be taken into account:

1. **Chemical dependency is a progressive illness.** Physical and emotional symptoms appear and progress and mental mismanagement is increasingly destructive. Spiritual bankruptcy is the end result. Premature death occurs.

2. **The disease of alcoholism is chronic in nature.** The goal is not to “cure” but to arrest the illness. There is no cure.

   **Total abstinence from all mood-changing chemicals remains as the only logical or viable goal.**

3. **The disorder must be viewed as a primary condition.** In due time it has its own specific symptoms. The primary condition is the delusion or impaired judgement which keeps the dependent person locked in self-destructive patterns. This must be dealt with first and continuously since it blocks any therapeutic process at all.

**Intervention**

Alcoholics are not in touch with reality. They often evade or deny outright any need for help whenever they are approached.

They are capable of accepting some useful portion reality, if that reality is presented in forms they can receive.

The classic counseling approach is ignored in attempting to confront an alcoholic personality.

Example: “Do you think you could get him in to see me”?

The goal of the counselor is to assist those people who can intervene more successfully – the “people who are the most meaningful in a person’s life” – the spouse, children, work associates, supervisor or boss.

In many cases, the supervisor is the most meaningful person in the life of an alcoholic. He measures his self-wealth by his ability to hold down a job. Also his job is important and in many instances he has already given up his family – the reason EAPs work.
Intervention and the Alcoholic (contd.)

Rules for intervening

1. Meaningful persons must present the facts. They must be people who exert real influence upon the alcoholic person. Family members, employer, management, etc. Specific time should be set up for confrontation with all present. The interveners may be professionals, i.e. counselors, clergy if they personally passes information which is useful. The employer is the most effective intervener.

2. Facts presented should be specific and descriptive of events which have happened on conditions which do exist: “I was there”, “I saw you do ....”. Evidence is strongest when it is firsthand. Opinions and generalization must be avoided. They tend to raises defenses and don’t work, i.e. “I think you drink too much or I think you ought to quit”.

3. The tone of confrontation should be non-judgmental. The information presented should show concern. The facts are simply items to demonstrate the legitimacy of the concern being expressed. Example “I am really worried what have been happening and these are the facts.

4. The chief evidence should be tied directly into drinking wherever possible.

5. The evidence of behavior should be presented in detail and very explicitly to give the sick person a broad and visual view of himself during a given period of time. Alcoholics themselves do not and cannot have this view because of their deluded condition. Videos of some of their drinking episodes will do best. No argument is possible and no denial can be made. This is reality and it is not the reality that the alcoholic has been believing it was.

6. The goal of the intervention, through presentation of the facts is to have the alcoholic see and accept enough reality so that however grudgingly, the need for help can be accepted.

7. Once the need for help has been accepted, the available choice must be offered. Abstinence is the foal. These are the alternatives this treatment center, that hospital or alcoholic anonymous. Firmness is necessary and you must follow through to the end decision. Allowing the alcoholic to make the decision or be part of it is to offer some sense of dignity.

The interveners must be clear in what they say. The alcoholic is manipulative and will make excuses if it is not clear.
INTERVENTION THROUGH CONFRONTATION
(Role Play)

Characters:

1. Glenda, a single middle-aged parent
2. Kimberly, her 18 year old daughter
3. Pat, the 16 year old daughter and an alcoholic
4. Lisa, Pat’s chemistry teacher in high school
5. Terri, the social worker

Background information:

Glenda, the mother, is in the process of divorce from her alcoholic husband. They had been married for 20 years, and Glenda’s husband’s drinking problem has been a consistent presence throughout their marriage.

Kimberly, the oldest daughter, has recently moved out of the house and is now living with her boyfriend.

Pat, the youngest daughter, has been observed to have a severe drinking problem. This prompted the mother to seek the help of a social worker. It was recommended that a meeting be held with Pat and the family, as well as significant others, to confront the drinking problem to Pat. Arrangements were made to meet at the school during the week following Pat’s classes in the afternoon.

Since Terri, the social worker, is also a certified alcoholism counselor, she carefully prepared the family for this meeting using Vernon E. Johnson’s guide on intervention. This not only included providing knowledge of the disease of alcoholism, but a means of confronting Pat with her problem.
<table>
<thead>
<tr>
<th>Points</th>
<th>Question</th>
<th>Yes</th>
<th>No</th>
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</thead>
<tbody>
<tr>
<td>0</td>
<td>Do you enjoy a drink now and then?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>(2)</td>
<td>1* Do you feel you are a normal drinker? (by normal we mean you drink less than or as much as most other people)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>(2)</td>
<td>2 Have you ever awakened the morning after some drinking the night before and found that you could not remember a part of the evening?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>(1)</td>
<td>3 Does your wife, husband, a parent, or other near relative ever worry or complain about your drinking?</td>
<td></td>
<td></td>
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<tr>
<td>(2)</td>
<td>4* Can you stop drinking without a struggle after one or two drinks?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>(1)</td>
<td>5 Do you ever feel guilty about your drinking?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>(2)</td>
<td>6* Do friends or relatives think you are a normal drinker?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>(2)</td>
<td>7* Are you able to stop drinking when you want to?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>(5)</td>
<td>8 Have you ever attended a meeting of Alcoholics Anonymous (AA)?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>(1)</td>
<td>9 Have you gotten into physical fights when drinking?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>(2)</td>
<td>10 Has your drinking ever created problems between you and your wife, husband, a parent, or other near relative?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>(2)</td>
<td>11 Has your wife, husband (or other family members) ever gone to anyone for help about your drinking?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>(2)</td>
<td>12 Have you ever lost friends because of your drinking?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>(2)</td>
<td>13 Have you ever gotten into trouble at work because of drinking?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>(2)</td>
<td>14 Have you ever lost a job because of drinking?</td>
<td></td>
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</tbody>
</table>

* Alcoholic response is negative
Michigan Alcoholism Screening Test (cont’d.)

<table>
<thead>
<tr>
<th>Points</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>(2) 15</td>
<td>Have you ever neglected your obligations, your family, or your work for two or more days in a row because you were drinking?</td>
<td></td>
</tr>
<tr>
<td>(1) 16</td>
<td>Do you drink before noon fairly often?</td>
<td></td>
</tr>
<tr>
<td>(2) 17</td>
<td>Have you ever been told you have liver trouble? Cirrhosis?</td>
<td></td>
</tr>
<tr>
<td>(2) 18**</td>
<td>After heavy drinking have you ever had delirium tremens (D.T.s) or severe shaking, or heard voices or seen things that really weren’t there?</td>
<td></td>
</tr>
<tr>
<td>(5) 19</td>
<td>Have you ever gone to anyone for help about your drinking?</td>
<td></td>
</tr>
<tr>
<td>(5) 20</td>
<td>Have you ever been in a hospital because of drinking?</td>
<td></td>
</tr>
<tr>
<td>(2) 21</td>
<td>Have you ever been a patient in a psychiatric hospital or on a psychiatric ward of a general hospital where drinking was part of the problem that resulted in hospitalization?</td>
<td></td>
</tr>
<tr>
<td>(2) 22</td>
<td>Have you ever been seen at a psychiatric or mental health clinic or gone to any doctor, social worker, or clergyman for help with any emotional problem, where drinking was part of the problem?</td>
<td></td>
</tr>
<tr>
<td>(2) 23 ***</td>
<td>Have you ever been arrested for drunk driving, driving while intoxicated, or driving under the influence of alcoholic beverages? If yes, how many times________</td>
<td></td>
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<tr>
<td>(2) 24***</td>
<td>Have you ever been arrested, or taken into custody, even for a few hours, because of other drunk behavior? If yes, how many times _________</td>
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</tbody>
</table>

** 5 points for delirium tremens
*** 2 points for each arrest

Scoring System: In general, five points or more would place the subject in an “alcoholic” category. Four points would be suggestive of alcoholism, three points or less would indicate the subject was not alcoholic.

Programs using the above scoring system find it very sensitive at the five point level and there is a tendency to find more people alcoholic than anticipated. However, it is a screening test only, and should be sensitive.


September 2000
1. Direct intervention in relation to substance use and abuse

2. Differential diagnosis of substance abuse and possible coexisting psychiatric disorders

3. Transference: Intensely ambivalent; Testing; Denial; and Grandiosity (see Characteristics of Alcoholics handout)

4. Countertransference: Intense feelings of frustration and anger; Therapist's need for omnipotence.

5. Support and redirect various defenses rather than attempt to remove.

6. Look for therapeutic leverage

7. Therapy carried out in stages designed to achieve control over impulse to drink.

R. Paul Maiden, Ph.D., LCSW – Intervention with Substance Abusers
# STAGES OF SUBSTANCE ABUSE TREATMENT

<table>
<thead>
<tr>
<th>STAGES</th>
<th>CLIENT STATUS &amp; LOCUS OF CONTROL</th>
<th>TREATMENT</th>
</tr>
</thead>
<tbody>
<tr>
<td>Stage I</td>
<td>“I can’t drink” (Need for external control)</td>
<td>Detoxification, Directive psychotherapy, Medication management, Self help (AA, CA, NA, etc), Family Therapy, Family self help (i.e. Al Anon).</td>
</tr>
<tr>
<td>STAGE II</td>
<td>“I won’t drink” (Internalized control begins to emerge)</td>
<td>Directive psychotherapy, Supportive psychotherapy, Consider discontinuing use of medications (except methadone), Self help – “Walk the walk and talk the talk” and recovery step progression.</td>
</tr>
<tr>
<td>STAGE III</td>
<td>“I don’t have to drink” (Conflict resolution)</td>
<td>Psychoanalytically oriented psychotherapy</td>
</tr>
</tbody>
</table>

R. Paul Maiden, Ph.D., LCSW – Intervention with Substance Abusers
Reactions to Troubled Employees

How serious does a problem have to be, before considering outside help?

Most of us do things the hard way, and far too long before asking for assistance. Of course, one can evaluate the importance of the employee to the organization, or the severity of their performance problem. Perhaps more telling is for the supervisor to look at their own reactions to the employee.

Have you felt:

- **Used** for trusting someone who is unreliable?
- **Angry** at the employee who uses personal problems as an excuse for poor performance?
- **Uncertain** about what to do; time and energy spent in rehearsing many alternatives?
- **Helpless** or cornered because you cared about someone and the caring interfered with being a good manager?
- **Afraid** to make appropriate demands on an employee for fear of making things worse for the already over-stressed person?
- **Guilty** for covering for an employee in an effort to relieve the pressure, or for not providing the right supervision?
- Besides looking at your feelings, you may look at your behaviors, or your thoughts. Do you find yourself:
  - **Avoiding** the employee, leaving the employee to whither or get into further trouble? Covering for the employee, doing their work or reassigning it?
  - **Gossiping** about the employee? Complaining about the employee to other people? Thinking about the employee in a circular way 'as you drive home from work?'
  - **Counseling** the employee or asking personal questions, giving suggestions, sympathies, pep talks, or "me-too-isms?"
  - **Praising** work which is only adequate and not really deserving of praise?
  - **Threatening** sometimes out of anger which later seems inappropriate to the immediate event which set it off, but not to the whole backlog?
  - **.Disciplining** as if the employee could change by willpower when he/she can't? Suspending someone with an attendance problem may be like punishing theft by giving more company property.
  - **Wanting to demote** or transfer the person.
  - **Wanting to terminate** the employee (or alternatively find a different job yourself)?
As a Supervisor How Do You Know When You Are too Involved?

You are too involved if you are:

- Carrying more responsibility for a problem than is the employee if you are more worried about a problem; if you are suggesting more solution than is the employee

- Feeling persecuted or victimized by an employee; or have alternating feelings

- Find yourself saying and doing things you wouldn't want your manager to know

- Uncomfortable with the personal information you are hearing
SOME CHARACTERISTICS OF ALCOHOLICS

Alcoholism is an illness not peculiar to any particular kind of person. It effects people with little or no regard for residence, political affiliation, intelligence, social position, color, wealth, occupation, etc.

Professional people are frequently in close contact with the alcoholic and the fallout of problem drinking. This list of characteristics of alcoholism is provided in an effort to stimulate understanding. It is by no means all-inclusive; the order in which these characteristics are mentioned has no particular significance. Such a listing does not mean that all alcoholics exhibit all of these characteristics but most do exhibit most of these behaviors at various points in their substance abuse history. Such a list should alert you to the possibilities of alcoholics exhibiting these behaviors. If you recognize and accept such behavior as an adjunct of alcoholism, you can better understand what some of the defenses you are going to deal with when you encounter an alcoholic.

**Denial.** The alcoholic inevitably has difficulty in recognizing his drinking or his alcoholism as a problem. Even though it might be perfectly obvious to you, the alcoholic's family, and many other people, the alcoholic just doesn’t believe that this is really a problem with him. Denial is as much a part of alcoholism as coughing is a part of having tuberculosis.

**Impulsiveness.** The alcoholic often does things on the spur of the moment, without considering the future aspects of his actions. He often acts impulsively, both in terms of beginning to drink or in doing other things, some of which get him into further difficulty. He is capable of understanding the inevitable results of these actions, but does not or cannot take the time to consider these actions before he acts.

**Evasion.** The alcoholic hides his drinking and does his best to avoid any reference to it or to associated matters. He will talk about the weather, his financial difficulties, his family problems, and often will emphasize these or other matters, however significant they may seem at the moment, in an effort to stay as far away as possible from the matter of his drinking.

**Projection.** The alcoholic generally attempts to rely rather heavily on the method of protecting himself from his alcoholism by blaming it on other people or circumstances. “Sure he drinks, and sure he often drinks in excess, but this is simply because his wife won’t let him drink at home! If she would permit him to have just a few drinks at home he would never drink in excess, and there would never be any difficulty!” His wife is therefore responsible for the difficulties he experiences. The problem therefore, is simply one of his wife. If she will change her ways or thinking or behaving there will be no alcoholic problem. Of course this is totally unrealistic, yet it seems ever so simple and clear to the alcoholic. Someone else or something else is responsible for his difficulties.

**Low Frustration Tolerance.** Little things seem to upset the alcoholic more than they upset many other people. He seems unusually sensitive to criticism, rejection, anger, or any situation which other people would perhaps not notice, or at least not react to so vigorously.

**Helplessness.** The alcoholic frequently feels that he has tried everything possible; he has done his very best to do something about the difficult situation in which he finds himself, but this has been to no avail. He feels that no one nor nothing can help him and therefore he does not follow through with any plans or means which might work.

**Ambivalence.** It is said that there are two sides to every issue. The alcoholic keenly senses both of these sides to the matter of drinking. He is extremely torn between stopping the drinking and getting another bottle. At one time he feels most sincerely that drinking is a problem; at another time that it is absolutely no
problem whatsoever. One moment he says he is through drinking and the next moment he obviously continues drinking. The alcoholic must be given every opportunity to recognize for himself this ambivalence about him. He will have difficulty considering both sides of his dilemma in an atmosphere which recognizes only one side. If you are intolerant either of abstinence or of drinking, you deprive him of the opportunity of an necessity for understanding himself as completely as possible.

Unworthiness. Over and over again the alcoholic makes statements to the affect that he doesn’t deserve the amount of time or attention that someone gives him. He feels that some people deserve the opportunities, interest, and efforts of other people but that he has been so bad and has done things so wrong that he deserves nothing except to continue to drink himself to death.

Manipulation. The alcoholic is a master at manipulating people and situations to his own advantage. Often quite readily someone makes a special arrangement for the alcoholic, vouches for him, protects him, or sticks his neck out in some way for him. After the person has been manipulated into this situation by the alcoholic, he is often disappointed rather quickly again by a recurrence of the alcoholic’s drinking.

Remorse. It is rather commonly felt that the alcoholic doesn’t experience remorse because if he did he wouldn’t continue behaving the way he does. One has only to allow the alcoholic the opportunity of expressing this remorse to learn of the huge amounts that he does experience and attempts to live with. Often his remorse is of such tremendous proportion that the alcoholic simply cannot live with it and must go and get himself another drink. Shaming, scolding, chiding, or increasing the remorse of an alcoholic in any way can serve only to intensify the alcoholic problem. This remorse is often expressed rather vividly by the alcoholic in statements to the effect that he feels so darn bad after he has been drunk and embarrassed his family, lost his job, or hurt himself physically, that he just cannot live with himself. He cannot stand the sight of himself to the extent that he shaves without using a mirror.

Rationalization. “I’ve only missed three days of work in the last two years because I was drunk,” brags one alcoholic. “I don’t drink nearly as much as those fellows who have been speaking at the Alcoholics Anonymous meetings,” protests another. “I can drink it or leave it alone,” are words that come from most problem drinkers at one time or another. These statements all come from people whose drinking problems are acute. To recognize the truth would be extremely devastating; drinking is their greatest need. If a choice has to be made between drinking and another item (Job, family, etc.) the drinking will usually remain and the other item will be sacrificed. Recognizing the importance of and necessity for drinking is so painful to the alcoholic that he cushions himself against this realization with the previous or similar statements and beliefs.

Sabotage. The alcoholic very commonly allows people to make plans or even helps make plans or arrangements and then sits back and throws a monkey wrench in their movement, generally by getting drunk. Any astute observations of alcoholics will illustrate the numbers of times that an alcoholic assisted in the wedding plans of his daughter, then gotten drunk and been unable to escort her down the aisle.

Dependence. The alcoholic often makes extremely heavy demands on someone whom he thinks has some interest in him. He asks impossible things, telephones at all hours of the night, expects someone to get him out of difficult situations or to hold his hand or to tell him whether or not to get a job. He needs someone else to be responsible for all that happens. Obviously, when something goes wrong, the blame then belongs to the someone else.

Low self-esteem. This is perhaps the most outstanding characteristic of the alcoholic. It often goes unrecognized because it is masked by an air of confidence or an attitude of “I can do anything” which is exhibited by the alcoholic. Real exploration of this attitude, however, indicates that the alcoholic is merely whistling in the dark while walking by the grave yard; acting as if he is not scared while his knees are clanging together in fright.
The alcoholic goes to great lengths to convince you that he has money, friends, influence, and many other things merely because he recognizes that he doesn’t. He puts on a big, bold front because he recognizes that the back of the store is empty. Often it is difficult for the alcoholic to recognize this low self-esteem about him. He has been fooling others and himself for so long that he simply doesn’t recognize this, he is apt to look at your feet and say, “Go ahead and kick me, I deserve it.”

**Hostility.** The characteristic alcoholic seethes with anger. Why shouldn’t he? Look at what people think of him, at the way he is treated, at what happens to him from a law enforcement aspect. Consider his prospects of getting employment, of being given medical or hospital treatment. Observe the way he is thought of by his family, his church congregation, and people in general. Wouldn’t you too be angry if you were treated the way the alcoholic is treated?

Some characteristics of alcoholics
November 2000
SOW 5712 – Intervention with Substance Abusers
R. Paul Maiden, Ph.D., LCSW

SUBSTANCE ABUSE ASSESSMENT GUIDE*

1. What were the precipitating events leading up to the client’s current crisis? (Was this problem in any way related to alcohol/drug use? How?)

_________________________________________________________________________
_________________________________________________________________________
_________________________________________________________________________

2. What role did the client take in addressing the problem? (Active – very involved, cooperative; passive – more or less doing as told or done to please others; resistant – ordered into treatment, given ultimatum by family, court or work, not identifying need to be in treatment).

_________________________________________________________________________
_________________________________________________________________________

3. Client’s perception of their chemical addiction:

___ Does not use ___ Experimental user
___ Recreational user ___ Prescription user/abuser
___ Regular user ___ Extensive user
___ (1 to 2 days per week) ___ (3-4 days per week)
___ Daily reoccupation with use ___ Dependent/addicted

4. What are the client’s feelings toward receiving treatment at this time?

_________________________________________________________________________
_________________________________________________________________________
_________________________________________________________________________

5. How have alcohol/drugs affected the client’s life?

_________________________________________________________________________
_________________________________________________________________________

(*Modified RAATE assessment guide)
6. What does the client state are the reasons for being here at this time? What do they want to accomplish?


7. What role does the client feel they have in their recovery?


7.1 Is the focus on themselves or on others needing to make changes?


7.2 What does the client state they need to do for their recovery?


8. Has the client had any prior involvement in chemical dependency treatment?

8.1 When, length of stay, and did the client complete treatment?


8.2 Has the client had any prior hospitalizations for alcohol/drug related reasons? (List reasons and dates).


9. Longest period of abstinence? (How long and why?)


9.1 Means by which the abstinence was maintained


9.2 Last period of abstinence longer than three days.

9.3 What was the period of sobriety like for the client?

9.4 Let the client give a brief description of events leading to their relapse.

10. What is the client’s understanding of alcoholism/drug abuse/addiction? To what do they attribute their addiction? (This question needs to be asked of both the client and the significant other)

When client was involved in past self help groups, what do they feel was gained by participation?

10.1 Does the client identify the need for self help group involvement in continued recovery?
11. Has the client experienced any of the following:

- Black outs
- Nausea
- Vomiting
- Seizures
- Hypertension
- Diabetes
- Visual hallucinations
- Loss of control
- Auditory hallucinations
- Withdrawal symptoms
- Tremors
- Sweating
- Craving chemicals
- Paranoia
- Violent behaviors
- Sleeplessness
- Stomach cramps
- Depression
- Morning drinking/using
- Using/drinking to sleep
- Use of drugs to counter effects of others

11. Has the client ever had a significant period (that was not the direct result of alcohol/drug use) in which he/she has:

- Experienced serious depression ____________________________
- Experienced hallucinations ____________________________
- Experienced trouble controlling violent behaviors ____________________________
- Experienced serious thoughts of suicide (with a plan) ____________________________
- Experienced serious anxiety or tension ____________________________
- Experienced trouble, remembering, concentrating or understanding ____________________________
- Attempted suicide ____________________________

12. Has the client ever been hospitalized for these emotional problems? (List the dates of hospitalization, the reason, lengths of stay, and most recent).

__________________________________________________________________________
__________________________________________________________________________
__________________________________________________________________________

13. Has the client taken prescription medication for any psychological or emotional problems? (List)

__________________________________________________________________________
__________________________________________________________________________
__________________________________________________________________________
14. What does the client feel is the family’s position regarding his/her alcohol/drug use? (Confirm this with collateral call).

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23. Are there any work consequences?

21.3 What is the role of the employer regarding client’s treatment?

21.4 Is the employer a source of leverage?

21.5 Is the workplace a prime source of client’s using system?

22. Is the employer/EAP (specify which) willing to:

___ Attend an employer session      ___ Be available for an intervention

23. Does the client have any pending legal problems?

23.1 Has the client had any alcohol/drug related legal problems in the past?
### SUBSTANCE USE HISTORY

<table>
<thead>
<tr>
<th>CATEGORY</th>
<th>SPECIFIC TYPE</th>
<th>ROUTE</th>
<th>AGE OF 1ST USE</th>
<th>AVERAGE AMOUNT USED</th>
<th>LAST USE / AMOUNT</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alcohol</td>
<td></td>
<td></td>
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<tr>
<td>Stimulants, i.e. Cocaine, Amphetamines, Speed, Ecstasy, Ritalin, Ketamine</td>
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<tr>
<td>Hallucinogens, i.e. LSD-acid, PCP-angel dust, mushrooms</td>
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<tr>
<td>Barbiturates, Seconal, Nembutal, Tuinal</td>
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<tr>
<td>Depressants (non-barbiturates), i.e. Qualludes, Valium, Placidyl, Librium</td>
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</tr>
<tr>
<td>Cannabis, i.e. Marijuana, Hashish, Inhalants, i.e. Paint, Thinner, Gasoline, Glue, Toluene, Acetone, Whippets, etc.</td>
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<tr>
<td>Narcotics (Opiates) i.e. Heroin, Codeine, Dilaudid</td>
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<tr>
<td>Analgesics/Synthetic Narcotics, i.e. Darvon, Walwin, Demerol, Methadone, Percodan</td>
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<td></td>
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<tr>
<td>Other, i.e., Antihistamines -Contact, Dristan; OTC Diet Pills; Sleeping Aids – Nytol, Compoz; Antidepressants – Elavil, Triavit; cough medicines</td>
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</tr>
<tr>
<td>Family History (member/substance (s) used)</td>
<td></td>
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</tbody>
</table>
Counselors assessment of this clients problem and recommended treatment based on the information collected.

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Counselor signature: ______________________ Date: ______________________
TREATMENT CENTER REVIEW AND ASSESSMENT

RESOURCE INFORMATION

Name of Facility
Address
City Zip code

Name and Title of person interviewed

1. Type of facility: Inpatient / Intensive Outpatient / Outpatient
2. Accreditation: JACHO, CARF, COA, NCQA, etc.
3. Licensure:
   a. What kind of licensure does facility hold?
   b. By whom?
   c. How many beds?

3. List types of service(s) provided
4. How long has the program been in operation?

TREATMENT SERVICES

5. What is the facilities theoretical orientation for treatment?
6. Is treatment limited to particular substances? (e.g. alcoholism only, cocaine only, etc.)
7. Does the facility accept patients with dual diagnosis (e.g. substance abuse and schizophrenia?)
   Yes / No
   If yes, explain how they care for and treat these patients.
   If no, what do they see as problematic?
9. Average length of the treatment program
10. Is there a detoxification service?
11. Length of detox?
12. Are AA/NA meetings: mandatory: Yes / No
    Recommended: Yes / No
    in-house: Yes / No
    community: Yes / No
    combination: Yes / No
13. What efforts are made to involve the family? (be specific – describe their family program)
14. Are there any provisions made for day care while the individual or family is in treatment?  
   Yes / No. If yes, please describe

15. What meetings are offered for family members?  
   Alanon______  Naranon_______  Alateen_____  ACOA ______

16. Describe the program's philosophy of aftercare and the aftercare program offered by the facility:

CLIENT DEMOGRAPHICS
17. What is the average income of clients?  Circle those that apply  
   Under $10,000  
   $10,000 to $15,000  
   $15,000 to $25,000  
   $25,000 to $40,000  
   $40,000 to $60,000  
   $60,000 to $80,000  
   $80,000 to $100,000  
   Above $100,000

18. What is the average education level of clients?  Circle most applicable.  
   Less than high school  
   High school or equivalent  
   Bachelors  
   Masters and above

19. What provisions are made in the program that account for gender, ethnicity, and/or culture?  (get specifics)

FINANCIAL INFORMATION
20. For profit / Not for profit

21. Range of fees for service(s).  If more than one service is provided, specify service and fee range.  

<table>
<thead>
<tr>
<th>Service</th>
<th>Fee range</th>
</tr>
</thead>
</table>

22. Type of payment accepted:  
   a. sliding scale  Yes / No  
   b. insurance  Yes / No  
   c. medical assistance  Yes / No  
   d. no fee for service  Yes / No

23. What is the minimum insurance coverage acceptable for admissions?

24. Do you reserve any beds for indigent clients or those unable to pay?

25. Do you accept walk-in clients or do you require an appointment first?  Explain
26. What is the length of time between a call for an appointment and the time service is initiated?

27. Is there an additional fee for service if the family is involved? If yes, please explain.

**PROFESSIONAL EXPERIENCE/TRAINING OF TREATMENT STAFF**

28. Academic degrees of staff hold? List type degrees

29. How many treatment staff do you employ?

21. Do you employ treatment staff who are recovering alcoholics/drug addicts?

22. Are treatment staff required to be certified alcoholism and/or drug abuse counselors?

23. What is your staff/client ratio?

33. Comments, observations, etc. (please summarize and provide an assessment of the facility based on your interview and visit. Attach additional page if needed).

Treatment center review and assessment
September 2000
I write at the conclusion of the course and I feel bound to offer twelve suggestions (Steps) of my own to help the Social Worker and Therapist:

1. We admitted we were victims of prejudice and erroneous concepts about alcoholism and alcoholics.
2. We came to believe that this was a serious impediment to the work of helping to restore the alcoholic to sobriety and sanity.
3. We made a serious and diligent study of the subject.
4. We made a searching and honest appraisal of our attitudes and disposition towards the alcoholic.
5. We gradually discarded our prejudices and acquired new knowledge and insights into the baffling disease of alcoholism and subtle complications of alcoholic behavior.
6. We sought to understand the alcoholic and were not afraid to achieve this by visiting with him in his home and his environment.
7. We attended AA meetings whenever possible.
8. We visited, counseled and supported the spouse and relatives of the alcoholic.
9. We constantly kept abreast with the latest developments on the subject.
10. We sought through meditation and study, not only to increase our knowledge of the subject but our capacity to love and understand.
11. We were willing to make sacrifices to become apostles of love and understanding to the still suffering alcoholic.
12. Having shed our prejudices and armed with new insights, we humbly sought, both by percept and example, to influence our fellow workers to undertake a similar exercise.

Christmah Sammy
PLUS/SAVE Assessment

Identifying Information

Student Alpha: _______ Date: ______ Caseworker: ____________________________

Name: __________________________ Age: _______ Grade: _______

School: __________________________ Home Phone: _________________________

Parent/Guardian: __________________________ Work Phone: _________________________

Home Address: __________________________

Work Location: __________________________

Reason referred: At-Risk _______ Suspected Use _______ Confirmed Use _______

Have you ever received or are you currently receiving counseling services?  Yes  No

If yes: (when/where/with whom) __________________________

Comments: __________________________

________________________________________

STUDENT PROFILE

Attendance:  Good _______ Fair _______ Poor _______

Recent drop in attendance:  Yes No

Discipline referrals:  Yes No

Recent suspensions:  Yes No

Expulsions:  Yes No

Current grades __________________________ Have grades dropped:  Yes  No

Recent change in schools?  Yes  No  Previous school(s) __________________________

________________________________________

Are you involved in any sports, clubs, hobbies, or any other interests?

Yes No  If yes, explain______________________________

________________________________________
FAMILY HISTORY

Who do you live with? (Parent/Guardian) ____________________________________________
________________________________________

Do you have brothers/sisters at home? Yes No
___________ Brother(s) – Age(s) or Grade(s) __________________________
___________ Sister(s) – Age(s) or Grade(s) __________________________
___________ Other __________________________

Has any member of your family ever had a problem with drugs or alcohol?
Yes No Explain __________________________
________________________________________
________________________________________

Have you or any member(s) of your family ever been abused? Yes No
Was this abuse reported __________________________
________________________________________
________________________________________

QUESTINNAIRE

EXPERIMENTAL USE/AT-RISK: Level 1

1. What grade were you in when you first experimented with alcohol or other drugs?
Grade ________________ Age ________________

2. How often are you using?
________________________________________

3. When was that last time you used? __________________________

4. Do you ever worry about getting caught? Yes No
REGULAR USE: Level 2
5. Does it take you more to get high than it used to? Yes No
6. Have you ever tried to quit? Yes No
7. Do you ever minimize the amount you use? Yes No
8. Do you ever use drugs or alcohol alone? Yes No

PREOCCUPATION: Level 3
9. Have you ever been arrested for any alcohol/drug-related incidences? Yes No
10. Do your friends use alcohol or other drugs? Yes No
11. How often do you come to school under the influence? ____________________________

12. Have you used drugs that you thought you would never try? Yes No

DEPENDENCY: Level 4
13. Does your day seem to go better when you are using? Yes No
14. Do you feel guilty when you drink or use drugs? Yes No
15. Do you fear getting caught soon? Yes No
16. Do you use even though you are experiencing negative consequences? (e.g., legal, Relationships, school, health, etc.) Yes No Explain ____________________________

COGNITIVE/EMOTIONAL
Do you ever feel too angry, depressed, or afraid? Yes No
If yes, explain: ________________________________________________________________

Have you or would you like to talk to someone else about this? Yes No
If yes, explain: ________________________________________________________________

Do you ever feel like hurting or killing yourself? Yes No
*If yes, explain: _______________________________________________________________
*If yes, transfer immediately to guidance for an Intent to Harm referral

Have you or would you like to talk to someone else about this?  Yes  No

If yes, explain: ________________________________________________________________

Have you experienced a major loss or change in your life?  Yes  No

If yes, explain: ________________________________________________________________

Do you belong to a gang/cult?  Yes  No

If yes, explain: ________________________________________________________________
PLUS Program

Case Disposition

Case Summary: ________________________________

______________________________

Recommendations: Level of Care -   Level 1 Level 2 Level 3

1. ________________________________

2. ________________________________

3. ________________________________

Referrals:  (Name, location, Phone)

1. ________________________________

2. ________________________________

3. ________________________________

Authorization for Release of Information signed by student:   Yes   No

Comments: ________________________________

______________________________

Student agrees to PLUS recommendations:  YesNo

Comments: ________________________________

______________________________

Sign: ________________________________    Date: ____________

Plus Caseworker

Sign: ________________________________    Date: ____________

Student
WARNING SIGNS OF RELAPSE

1. Apprehension about well-being.
2. Denial.
3. Adamant commitment to sobriety – I will never drink/drug again – don’t need help.
4. Compulsive attempts to impose sobriety on others – now that I’m clean you have to be too.
5. Defensiveness.
6. Compulsive behavior.
7. Impulsive behavior.
8. Tendencies toward loneliness – patterns of isolation and avoidance increase.
9. Tunnel vision – focus on one area – lack of creativity – need to empower our patients to always see that they have options.
10. Minor depression.
11. Loss of constructive planning.
12. Feelings of hopelessness – plans begin to fail.
13. Idle daydreaming and wishful thinking.
14. Feeling that nothing can be solved.
15. Immature with to be happy – person cannot identify exactly what they want – just to be happy.
16. Periods of confusion (confusion = not being able to make a decision).
18. Easily angered.
19. Irregular eating habits.
20. Listlessness – extended periods of inability to initiate action – unable to concentrate and to stay focused.
21. Irregular sleeping habits.
23. Periods of deep depression.
25. Development of I don’t care attitude.
27. Dissatisfaction with life – things are so bad, couldn’t get worse, might as well drink.
28. Feelings of powerlessness and helplessness.
29. Self pity.
30. Thoughts of social drinking.
32. Complete loss of self-confidence.
33. Unreasonable resentments.
34. Discontinuing all treatment.
35. Overwhelming loneliness, frustration, anger and tension.
36. Start of controlled drinking.
37. Loss of control.

**RELAPSE PREVENTION PLANNING**

1. Stabilization – getting control.
2. Self-assessment – find out what is going on. Are you congruent for thought, feeling and action.
3. Relapse education.
5. Warning sign management – learn to interrupt patterns before loss of control.
6. Inventory training – learn how to become consciously aware of warning signs as they develop – 10th step.
7. Develop support system.
8. Share what’s going on with program people, significant other.
What is Relapse?

Relapse is defined as returning to a specific behavior after a period of abstinence (stopping), that particular behavior. Relapse does not come on suddenly and without warning, it is a process over time. Staying clean/sober is not recovery, working a program is. Relapse cannot be avoided by shear willpower or self-discipline.

SELF-TEST FOR RELAPSE WARNING SIGNALS

Here is a simple list of questions that indicate relapse symptoms. Check each one off when your life is not going like you feel it should.

- Do you feel you have a lack of personal confidence to remain clean/sober or abstinent?
- Are you in denial? Do you find yourself trying to convince yourself or others that you will never ever drink or use again?
- Do you start imposing recovery on other people?
- Do you become defensive when talking about your problem in recovery?
- Have compulsive behaviors appeared, or have you adopted a non-structured lifestyle?
- Do you over-react, or are impulsive behaviors beginning to appear?
- Are you experiencing periods of loneliness?
- Have you begun to focus on one certain area in your life, and are you unwilling to shift your focus? (TUNNELVISION)
- Are you experiencing periods of minor depression?
- Are you experiencing a loss in the ability to plan constructively where attention to details lessen and wishful thinking begins?
- Are your plans beginning to fail?
- Do you find yourself daydreaming more often and is the "if only" syndrome entering into your daily routine?
- Do you feel that nothing can be solved?
- Are you vocalizing the immature wish to be happy, while feeling that you do not know what happiness is?
- Are you experiencing periods of confusion?
- Are you behaving irrationally with friends and family?
- Are you easily angered?
- Do you have irregular eating habits?
- Do you feel you have an inability to concentrate, feel full of anxiety, or have feelings of being trapped?
- Has there been a progressive loss of daily structure?
• Are you experiencing periods of deep depression?
• Have you had increasingly irregular attendance at recovery meetings?
• Have you developed an "I don't care" attitude?
• Are you openly rejecting help?
• Are you becoming dissatisfied with life?
• Do you have feelings of powerlessness and helplessness?
• Do you spend time wallowing in self pity?
• Are you having thoughts of social drinking/using?
• Are you experiencing conscious lying?
• Do you have a complete loss of self-confidence?
• Are you harboring unreasonable resentments?
• Have you discontinued attendance at recovery meetings altogether? ("developed an I don't need them attitude")
• Do you feel overwhelming loneliness, frustration, anger and tension?
• Have you started "controlled" drinking and using?
• Are you feeling a loss of control?

If you can relate to the warning signals found above, or if you find yourself using the "Relapse Danger Words" listed below, you are in a relapse stage. The severity of your stage of relapse will depend on how many of the behaviors listed above you're now experiencing.

Relapse is a complicated problem. It is something that has numerous warning signs and many plans of attack, but without help and a serious commitment on your part, it will win and you will lose. Avoiding fun, over analyzing yourself, blaming other people, too much or too little sleep, or trying to make a major life change in the first year of your sobriety, are all danger signs that you are entering into an area that may take you somewhere you don't want to go.

RELAPSE DANGER WORDS: I Forgot Maybe Kinda Someway I'll Try This is BS I Don't Know More or Less Sorta I Can't As I Can Who Cares Problem! I Guess Sometimes I Don't See How It's Too Hard You're Picking On Me

Relapse can be avoided. You will have to be honest, open and willing to deal directly with each symptom as it appears. Without help, it is too much for us. Recovery is a process that gives us the choice of life or death. Addiction leaves us no choice but death.
Statistics
- 1 out of 10 women are alcoholic.
- 2.25 million women have alcoholic/drug problems.
- 1/3 membership of AA is women.
- 45% of cocaine admissions are women.
- 18% of opiate-dependent (heroin, narcotic) population is female.
- 36% of the female population is addicted.
- Alcohol is the number 1 drug of choice for women.
- High percentage of women with alcohol and valium addiction.
- Women have a high tendency to be dually addiction.
- Cocaine is fast becoming women’s choice of primary drug with or without usage of alcohol.
- High percentage of women who are chemically addicted also have eating disorders.

Special Populations and Problems
- Addiction is cross-populated, effects of all ages, races, classes, social-economic backgrounds.
- Double standard in society; men are accepted for addicted behavior, women are criticized as “lush, hooker, unladylike”.
- Women tend to hide addiction, making them harder to reach, less likely to seek help, more likely to become seriously ill before disease is diagnosed.
- Women have greater difficulty remaining in treatment; programs are generally geared toward men, traditional conceptualization of addiction, lack of sensitivity and support to women’s issues and concerns. Women are externally focused; sense of worth from others’ approval, compliant to authority figures.

Significant Differences between Men and Women
- Women begin to use and experience addiction later.
- Women drink more often at home, alone, or with a partner.
- Women use cocaine more readily in date situations.
- Women have shorter drinking bouts.
- Women use alcohol more to improve work performance.
- Women use more alone.
- Women perceive addiction as becoming worse.
- Women use/abuse prescription drugs more than men.
- Addicted women are more prone to suicide attempts than men.

Effects and Patterns of Addicted Women
- Conceal problems longer; seek treatment later than men.
- Abuse additional drugs.
- Neglect children.
- Experience depression, withdraw from social networks.
- Deserted; 9 out of 10 women are deserted by their spouses when addiction becomes severe.
- Birth defects-FAS, retardation, stillbirths.
Addiction
- Loss of control.
- Compulsive usage.
- Usage in the face of undesired consequences.

Physiological Problems
- Alcoholism appears to progress more rapidly in women.
- Women become addicted sooner and faster than men.
- Women have lower tolerance (body weights).
- Women report experiencing feeling more intelligent, capable, and attractive while using but feel supersensitive.
- Poor diet habits, hypoglycemia.
- Women experience weight gain and loss; eating disorders.
- A high proportion of addicted women experience infertility, menstrual disorder, dysmenorrhea, amenorrhea.
- Women drink and use more before menstrual period.
- High correlation of PMS-addiction symptoms (tension, depression, anxiety, fatigue, water retention, sweet cravings, swellings, vomiting).
- Decrease in sexual drive; frigidity, inorgasmic, decrease in vaginal lubrication.

Psychological Problems
- Escape from problems, depression, anxiety.
- Ease pain, loneliness, isolation, boredom.
- Family stress.
- Interpersonal problems.
- Low self-esteem.
- Medical crisis.
- Sexual problems.
- Lack of fulfillment.

Social Factors
- Sexism of addictive women.
- Partners tend to abandon addictive women.
- Significant other’s perception and concern, feelings of guilt, worry, helplessness, anger; conflict about relationships, loss of dependability, inability to set goals, financial problems, embarrassment, deteriorating communication.
- Effects on family, children and work.

Treatment Recommendations
- Need for self-care, understanding physical symptoms of addiction, implications of menses and understanding emotional problems.
- Basic caretaking; diet, sleep, baths, exercise.
- Individual treatment.
- Group support, networking (NA and AA groups for women).
- Women sponsor.