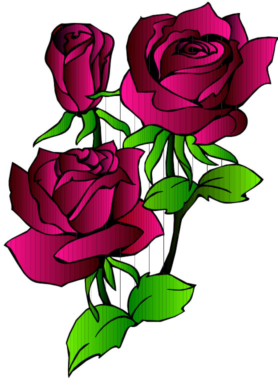

THE DELIVERY AND SUPERVISION OF OUTREACH SERVICES

Project SAFE

Illinois Department of Human Services
Office of Alcoholism and Substance Abuse
100 West Randolph Street, Suite 5-600
Chicago, Illinois 60601
Nick Gantes, Associate Director

DHS Project Coordinator:
Maya Hennessey

Authors:

Part I: William L. White
Pamela Woll
Susan Godley

Part II: William L. White

Content Consultant:
Jan Motsinger

Lighthouse Institute Project Coordinator:
Randall Webber

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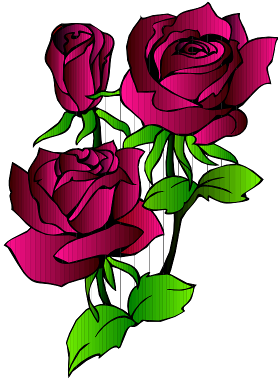

THE DELIVERY AND SUPERVISON OF OUTREACH SERVICES

Part I:

Voices of Hope: An Orientation Manual for Outreach Workers

You were always there for me,
the tender wind that carried me.
A light in the dark,
shining your love into my life.
You've been my inspiration,
through the lies you were the truth.
My world is a better place because of you.

You were my strength when I was weak,
You were my voice when I couldn't speak.
You were my eyes when I couldn't see,
you saw the best there was in me,
lifted me up when I couldn't reach.
You gave me faith, 'cause you believed.
I'm everything I am because you loved me.

From "Because You Loved Me"
Words and Music by Diane Warren
Performed by Celine Dion

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Warner Bros. Publications

Voices of Hope
An Orientation Manual for Outreach Workers

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Introduction

During the past ten years, Illinois has pioneered an innovative approach toward addressing the collision of maternal substance abuse and child maltreatment within the state. This initiative began with a Department of Health and Human Services demonstration grant that brought together the resources of the Illinois Department of Alcoholism and Substance Abuse (DASA) and the Illinois Department of Children and Family Services (DCFS), as well as local community resources, to provide substance abuse treatment to women with histories of abuse or neglect of their children. Between 1986 and 1996 this initiative, which came to be known as Project SAFE, spread to nineteen Illinois communities and treated more than 5,000 women and their families.

One of the most innovative aspects of Project SAFE is a style of outreach work that has eliminated many of the obstacles that have kept significant numbers of women from entering or successfully completing substance abuse treatment. The outreach services have been such an important part of the success of Project Safe that these services have been emulated in additional Illinois projects that involve collaborative efforts between DASA and DCFS. While our knowledge of how to deliver these outreach services has grown, it has existed primarily as a body of oral folklore passed from worker to worker. While this body of folklore is a rich one, much knowledge has been lost as outreach workers and their supervisors have changed positions within the field or left the field for new endeavors. This manual is an effort to stem this loss of knowledge.

The Outreach Worker Orientation Manual is designed to provide support to local agencies in their efforts to recruit, train, and supervise outreach workers who are working with addicted women and their families. The Manual has been designed for the widest possible utility. It may be read by a new outreach worker. It can serve as a framework of orientation used by an agency supervisor to acclimate a newly hired person to the role of outreach worker. It is also designed to be used as a training manual for regional or statewide orientation sessions for new outreach workers. A companion manual that also includes training tips and discussion guidelines for use with this manual has been developed for supervisors of outreach workers.

The information in this manual is drawn from the following sources: 1) a review of the professional and folk literature on the treatment of addicted women and their children, 2) information drawn from reports on evaluations of Project SAFE, and 3) interviews with Project SAFE outreach workers and outreach worker supervisors that were conducted in the Spring of 1996.

The addiction treatment field has struggled for more than a century to address the special needs of women and their children, and the greatest breakthroughs in service to these clients have occurred in the past twenty years. It is our hope that this manual will mark one more step in the progress toward the development of a gender-specific and circumstance-specific model of addiction treatment.

This manual is dedicated to the outreach workers and outreach worker supervisors who for the past ten years have helped sculpt a role that has made a profound difference in the lives of so many women and children in Illinois. Through your skill and your perseverance, you have touched the hearts of these women and children and improved the quality of life in our communities and in our state. We thank you.

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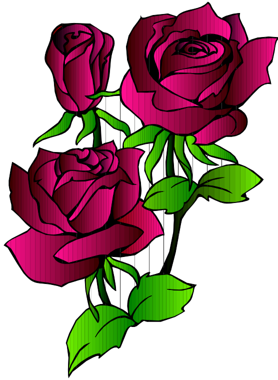

Section 1.0
Our Clients

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1.1 Addicted Women and Their Children

Learning Objectives

1. Identify at least three substance abuse trends that are having a significant effect on women and children.
2. Discuss the clinical profile of addicted women with histories of neglect or abuse of their children.
3. Discuss the implications of this clinical profile for the delivery of effective outreach services.

Drug Trends

Since 1980 there have been several dramatic changes in the nature of substance abuse in the United States.

The first area of change involves the drugs themselves. In the past fifteen years, we have seen a rise in the availability of drugs, a lowering of price that has brought drugs like cocaine into the reach of a broader range of people, and the appearance of more powerful forms of drugs and more efficient methods of taking them. Nowhere is this trend more evident that in the rise of cocaine addiction in the United States between 1982 and 1990. This trend had a profound impact on child welfare systems in the United States, primarily through a dramatic rise in the number of drug-exposed babies. Placements of children in New York increased fivefold between 1982 and 1990, while placements in California rose from 36,000 in 1982 to more than 75,000 in 1989. The number of drug-exposed babies reported to DCFS in Illinois rose from 297 in 1986 to 2,399 in 1990.

Cocaine continues to be the primary drug of choice of women entering treatment, but two new trends are also worth watching. First, a pattern of polydrug abuse (abuse of more than one drug) is beginning once again in the United States, marked by the increased use of cannabis, hallucinogens (including PCP), methamphetamine, and inhalants. The second trend involves an increase in the use of high-purity heroin, either by intranasal administration (“snorting”) or by smoking. These increases in heroin use are occurring in two populations: 1) former cocaine users, and 2) a new generation of heroin users drawn from a cross-section of ethnic groups and social classes.

What might be some of the implications of these two trends for projects that intervene with substance-abusing mothers who neglect or abuse their children?

A second area of change noted in the past two decades involves fundamental changes in the characteristics of people who abuse drugs. The first of these changes is that people begin abusing substances earlier in life. Many late adolescents and young adults entering treatment today report that they started abusing alcohol and/or other drugs at very early ages (for example, at 9-12 years old). The second change is the substantial rise in substance abuse by women in our culture.

What factors do you believe may have contributed to the rise in alcohol and other drug use among women and young people?

A third area of change involves the circumstances that tend to surround substance abuse in the United States. This change is marked by more and more intense drug-related criminal activity (related to cocaine), a rise in drug-related violence, and a rise in drug-related disease. Today we are much more likely to have women entering treatment who have been victimized by crime and violence and have participated in criminal and aggressive acts themselves. Substance abuse is also the fastest-growing risk factor related to the spread of HIV/AIDS in the United States. According to a 1996 report from the Centers for Disease Control, 28 percent of people diagnosed with AIDS report drug injection as their primary risk factor. Fifty percent of heterosexuals with AIDS are or have been partners of people who inject drugs. Seventy-two percent of children with AIDS were infected because of drug injection by one or both parents.

What are some of the implications of this group of trends for programs that serve women and children?

Clinical Profiles of Addicted Women: Service Delivery Implications

Substance Abuse Patterns

- Most women entering treatment are poly-addicted—addicted to more than one drug. Women are much more likely than men to be using more than one drug, and to be using both prescribed and illegal drugs at the same time.
- The beginning of substance abuse in women is often tied to a particular life event, like the beginning or end of a relationship, a death, hysterectomy or mastectomy, the beginning of menopause, etc. In many cases, such an event precipitates a move from substance use to substance abuse, or from the therapeutic use of prescription drugs to misuse of such substances.

- Alcoholism (and perhaps other addiction) progresses more rapidly in women.
- Addicted women report beginning use, increasing their use, and increased risk of relapse during premenstrual days.

Family and Developmental Histories

- More than 70 percent of women entering addiction treatment in Illinois report that one or both parents had a substance abuse problem.
- Self-reports of childhood sexual abuse by women in treatment range from 50 to 95 percent. Compared to non-substance-abusing women, substance-abusing women are more likely to have experienced sexual abuse beginning early in life, abuse over a long period of time, more than one sexual perpetrator, and more physical violence or threats of violence accompanying the sexual abuse. More substance-abusing women also report that they were not believed—or they were blamed—when they broke silence about the abuse.

What implications might this history pose for the following:

Mother-child relationships____

____

Adult intimate relationships____

____

Ability to trust people in helping relationships________________________________

____

Tendency toward excessive behavior (risk-taking, crisis-orientation, etc.) __________

____

Physical Health

- Women develop more complications from alcoholism after shorter periods of drinking and with less alcohol intake.
- Addicted women have a higher risk of obstetrical/gynecological problems, liver disease, cancer, and sexually transmitted diseases (STDs) than other women.
- Addicted women have a much higher risk of accidental death from synergistic drug interactions—where the *combination* of two or more drugs is much stronger than the added effects of the drugs themselves—than men have.

Because addicted women have such a high physical vulnerability, it is absolutely essential that these women be linked with health care resources for screening and treatment. Complaints of physical problems during early recovery should never be ignored.

Emotional Health

- Nearly half of the women entering Project SAFE in Illinois had been diagnosed with one or more psychiatric disorders other than alcoholism/addiction before they entered the Project. The most frequent of these diagnoses are depression, bipolar disorder (formerly called "manic-depressive disorder"), anxiety, and borderline personality. Addicted women entering treatment often report past thoughts of—and attempts at—suicide.

It appears that a significant percentage of women entering addiction treatment have both emotional problems and substance abuse problems. What are some potential implications of this for the delivery of outreach services?

____

____

____

Intimate Relationships

- Addicted women are more likely to choose partners who have psychiatric problems that are similar or related to their own.
- Addicted women are more likely to choose partners who come from family backgrounds similar to their own.
- Addicted women present a general pattern of unstable intimate relationships, low levels of emotional satisfaction, and increased levels of conflict that can escalate into emotional/physical abuse.

Describe at least two implications of the above for the design of treatment programs and outreach services for addicted women with children.

1. ____

   ____

2. ____

   ____

Sexuality

According to the research of Stephanie Covington, alcohol and other drugs may play a dual role in addicted women's sexual problems. These drugs may temporarily relieve the symptoms of some of these problems, but they also tend to make the problems grow worse over time.

Obstacles to Treatment

- Women who have had a hard time entering and/or completing addiction treatment have

reported a number of obstacles, including inadequate child care resources, inadequate transportation, enabling (the inadvertant support of addiction through such mechanisms as the removal or withholding of addicion-related consequences by family members, friends, or co-workers), lack of financial resources, the stigma of being identified as addicted or needing help, restricted hours of agency services, and discomfort with male-oriented treatment philosophies and approaches.

- Women tend to enter treatment at later stages in the progression of addiction than men.

The primary reason for providing high-intensity outreach services is the presence of significant obstacles that keep women from entering and completing addiction treatment. Outreach services are designed to help women overcome these obstacles.

Substance Abuse and Parenting

Most studies of addicted mothers in treatment note a clear relationship between the beginning and worsening of substance abuse and the loss of their ability to fulfill their responsibilities as parents. Most clients in treatment report that incidents of neglect and overindulgence (in response to guilt) increased as their drug use progressed.
Although women who get clean and sober often show significantly less neglect of their children's needs, sobriety alone is often not enough to turn people into effective parents. Women often need interventions like parenting training and parenting coaching, so that they can learn and adopt effective parenting practices and "un-learn" the counterproductive parenting habits that may have existed before they began drinking and using addictively.

The link between substance abuse and child abuse is a complex one. The best predictor of a woman's risk to abuse her child after substance abuse treatment may have more to do with her own childhood history than with her substance abuse as an adult. Substance abuse may contribute to child abuse, rather than cause it. In assessing risk to the child, it's not enough to ask whether or not the mother is continuing to use drugs. This assessment should be based on a much broader field of information, including the woman's own developmental history.

What practical implications flow from these understandings? Record your observations below:

____

____

____

Service History
Many addicted women and their families have long histories of failed interventions by health and human service agencies, as well as by other community institutions such as the schools, the courts, and the churches.

Some addicted women show chronic self-defeating styles that tend to sabotage efforts at involvement with helping professionals.

A barrier that prevents many addicted women from entering and/or completing treatment is a deeply rooted style of passivity, helplessness, hopelessness, and dependency (on drugs, people,

and institutions).

If a woman has a long history of negative involvement with helping institutions, describe what you should expect as this client opens her door to you for the first time.

____

____

How might you get through this resistance and develop an authentic (honest and effective) helping relationship?

____

____

Resiliencies

We've come to recognize that many character traits and interaction styles that have traditionally been seen as pathological in addicted women are really signs of resilience—survival strategies that might have been necessary in childhood or in the drug culture, but don't work for adult women in sobriety. In light of the developmental histories of addicted women, how might each of the following traits been a strategy for physical and/or psychological survival?

A high distrust of others____

____

Manipulation ____

____

Crisis orientation____

____

Lack of self-observation____

____

Lack of empathy____

____

High risk-taking behavior____

____

Make a list of the resiliencies of a client you are currently serving, by identifying the traits, abilities, and internal and external resources the client has that might support her recovery.

Resiliency List

1. ______________________________

2. ______________________________

3. ______________________________

4. ______________________________

5. ______________________________

Reading Resources

Crack and Other Addictions: Old Realities and New Challenges for Child Welfare (1990). Washington, D.C.: Child Welfare League of America.

White, W.L. (1990). *Project SAFE Program Handbook.* Springfield, IL: Illinois Department of Children and Family Services.

Wilsnack, S. and Beckman, L. (1984). *Alcohol Problems in Women: Antecedents, Consequences and Interventions.* New York: Guilford Press.

Women and Alcohol: Health-related Issues (1986). NIAAA Research Monograph No. 16. Washington D.C.: U.S. Government Printing Office.

1.2 Multiple-Problem Clients and Families

Learning Objectives

1. Discuss at least two reasons why traditional service models have failed when applied to multiple-problem clients and their families.
2. Describe at least four elements of emerging multiple-problem client intervention models.
3. Describe the three primary functions of outreach workers in serving multiple-problem clients and their families.

Client Profile

We would like to introduce you to a family that has many problems and a long history of involvement with health and social service systems.

> *Maggie is a 23-year-old woman who has an eight-year history of substance abuse and a three-year history of cocaine addiction. She is an adult survivor of childhood sexual abuse. She has been hospitalized twice for suicide attempts and was diagnosed in the past with acute depression and borderline personality disorder. She has been involved in a long string of abusive relationships; and there have been domestic violence issues with her current paramour, who resides with Maggie and her children most of the time. Maggie has three children, the last two of whom were delivered drug-exposed. Two of Maggie's children have been returned to her after placement, and the third continues to live with her mother. Maggie's family has all but abandoned her, mostly because of her constant demands for money and her theft of property from family members. Maggie has been thrown out of her home twice in the past eighteen months, because money that should have gone toward the rent was spent on cocaine instead. Maggie has also had brushes with the law, mostly for shoplifting to get money for cocaine. Maggie's children show a number of developmental delays, and two of them are already showing emotional/behavioral problems. Maggie has no transportation to and from treatment and no current resources for child care. If we examined the involvement of Maggie and her children with service agencies over the past eight years, we would find a remarkably long history of brief interventions by a large number of agencies. Can you imagine how many dollars and how many staff hours from hospitals, clinics, schools, probation offices, and other social service and criminal justice agencies have been expended over these eight years? Maggie's story is typical of a growing number of multiple-problem clients and families who are caught up in the child welfare system and involved with a variety of allied agencies*

1. Would you guess that the quality of life and level of functioning of Maggie and her family is better today than it was eight years ago? ___Yes ___No

2. Please identify factors that may have contributed to the failure of these many service

interventions during the past eight years.

____

____

____

____

Failed Service Interventions

A growing understanding exists that, in a categorically segregated service system (agencies organized by individual problems), multiple-problem clients and families often fail. This failure is due to the following pattern of intervention:

Focus of the Intervention

Interventions focused on one problem at a time may fail because of the disruption produced by so-called "secondary" problems. There is a clear circular pattern and inter-connectedness among the problems in Maggie's life. This dooms to failure any intervention that focuses on a single problem without addressing the many other troubles that contribute to and spring from that problem. The focus of many failed interventions defined the problem as existing primarily inside the individual, rather than in the family system, kinship network, or broader social/economic environment.

Provider of the Intervention

Interventions delivered by one agency at a time—and often by one program and one discipline within an agency at a time—frequently fail because: 1) the assessment process is not comprehensive enough; 2) the client's problem is misdiagnosed (often because of the inadequate assessment); and 3) the intervention is too narrow (it addresses only one problem within a multi-problem client or kinship system).

Timing of the Intervention

Interventions with multiple-problem clients generally are crisis-oriented in nature.

Duration of the Intervention

Interventions with multiple-problem families often last only a short time, with service providers withdrawing or being removed from involvement before temporary changes can be instilled as permanent changes in lifestyle.

Environmental Obstacles

> Many interventions with multiple-problem families ignore the real-life obstacles (for example, lack of child care and transportation, the problem of living in violent and drug-saturated neighborhoods) that can undermine effective service involvement.

Emerging Service Models

Project SAFE and The DCFS/DASA Initiative represent an effort to develop more effective models of serving multiple-problem clients and families. These new models tend to:

- Involve the pooled resources of **multiple agencies** at the federal, state, and local levels and the combined expertise of **multiple professional disciplines**. The model is **team focused**.
- Use an assessment process that emphasizes abilities and potential as well as deficits **(strength based rather than deficit based)**.
- Use aggressive programs of **outreach** and **case management** to engage the client and integrate the services from multiple agencies into a meaningful whole.
- Use a stage of **pretreatment,** with the primary goal of building a relationship with the client and instilling in her a sense of hope for the future.
- Attempt to treat the **whole family**.
- Address environmental obstacles to sustained service involvement, such as **child care** and **transportation**.
- Increase the **intensity and duration** of service involvement.
- Focus on a lifestyle-building process that involves and is supported by community-based resources.
- Help clients Identify and understand address clients' acts of **self-sabotage**, particularly passivity, learned helplessness, learned hopelessness, and dependency, and suggest more effective alternative styles of behavior.
- Rely on a service design that is highly **structured but flexible** to assist the client in working through the boundary testing that is typical during early stages of treatment.
- **Most important**, use a treatment design that is both **gender-specific** and **culturally appropriate**.

The Importance of Outreach

Outreach workers are the glue that makes our Illinois models work. Outreach workers are essential in: 1) engaging clients, 2) supporting clients through the continuing service-delivery process, and 3) linking clients to community resources that can help them sustain the progress they've made in treatment.

When DCFS workers and other community agency representatives were asked what role

outreach had played in the treatment of addicted women and their families, they were unreserved in their praise for the difference that outreach services had made:

> *Most of the clients I referred to Project SAFE wouldn't even have started treatment if it weren't for the persistence and encouragement of the outreach workers.*
>
> *Outreach services, and the case management activities integrated within those services, is our best attempt to piece together an integrated service plan out of a highly fragmented service delivery system. It's the outreach worker who keeps it all connected and jumps in to patch up glitches that occur in our systems of care.*
>
> *I think the biggest contribution of the outreach worker is in taking care of those very real problems that often kept women from starting or completing treatment—things like child care, transportation, and all the other daily problems that arise to keep women from getting to treatment.*

Here's what some clients had to say about what their outreach workers meant to them.

> *At first, I didn't want to come, and I didn't want to quit using, but Jan* [the outreach worker] *came knocking on my door every day, telling me I was going to make it to treatment no matter what. She would hunt me down and do whatever it took to get me involved. At first, she was a pain in my ass. But what I got out of it was a true friend—somebody I can trust. She's changed my whole life.*
>
> *It was her* [the outreach worker's] *persistence. She just kept coming around, you know, wearing me down. I got to thinking, "She ain't gonna leave me alone, so I might as well see if I can do it their way." And that's when I started to change.*
>
> *They* [the outreach workers] *can't do it for us. We got to do it ourselves. But they're there to stand by you and back you all the way.*
>
> *I've had a hard life and trusting ain't easy for me, but I can honestly say I got some trust now. I was hateful at first—I hated them all* [the agency staff]. *I thought they were all just doing their jobs, but she* [the outreach worker] *convinced me that it was more than a job—that she really cared about what happened to me and my children.*
>
> *She's* [the outreach worker] *been a cross between a friend and a mother—you know—loving but tough. She loves you, but she don't take no shit from no one.*
>
> *She* [the outreach worker] *was there to give me advice and be someone I could talk to openly about certain things. It was knowing that she would be there for me that helped get me through* [treatment].
>
> *She* [the outreach worker] *was always there when I needed to talk. And she'd always tell me to keep my head up, that things were going to work out.*
>
> *She* [the outreach worker] *helped me find a new way of life that I'm really excited about.*

I'll always appreciate the way she gave me hope.

We asked some clients in Project SAFE what advice they would give a new outreach worker. They all found a way to talk about the quality of patience.

> *Let them know that we are ladies that have gone through some hard times in our lives and to try to be patient with us and to be there when we need to talk.*
>
> *Be patient with us.*
>
> You got to put yourself in our place and be patient. It is very hard to get clean of drugs. Don't judge us; support us. Help those of us whose only goal was drugs get a positive goal.

Exercise

Having reviewed the material in this module, discuss how outreach services can contribute to the success of clients who have failed in programs that lacked outreach services. Jot down your ideas in the space provided below.

____

____

____

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1.3 The Dependency Cluster

Learning Objectives

1. Identify the developmental stages of recovery most frequently experienced by women who successfully complete Project SAFE.
2. Discuss the implications of the "developmental model of recovery" for the role of outreach.

In the Appendix you'll find a paper entitled "A Developmental Model of Recovery." After reading the paper, complete the following true-and-false test. Discuss the answers with your supervisor or in your small discussion group.

True or False

___1. The term "toxic dependency" refers to the relationships that addicted women have with drugs, people, and helping institutions.

___2. The earliest developmental stage of recovery for addicted women involves issues of safety and trust.

___3. Women aren't ready for treatment until they hit bottom and experience a sincere desire to get sober.

___4. Many addicted women are, by themselves, constitutionally incapable of breaking their toxic relationships with drugs, people, and enabling institutions.

___5. The *primary* role of outreach workers in client engagement is to increase the client's experience of pain and consequences related to her drug use.

___6. Prospective clients who are experiencing low levels of hope and low levels of pain have a good prognosis for entering and successfully completing treatment.

___7. The most important tasks of the outreach worker are working through client resistance and eliminating obstacles that interfere with her ability to enter and complete treatment.

___8. The outreach worker's relationship with each client changes during the different developmental stages of recovery.

___9. What is appropriate and helpful to do for a woman in the early stages of treatment may be inappropriate and harmful in the late stages of treatment.

__10. During the stage of sisterhood, when clients bond closely with one another, this peer

influence can work either to support or to sabotage recovery.

__11. The primary role of the outreach worker in the late stages of treatment is helping the client reconstruct a lifestyle and a sobriety-based support structure in the community.

__12. Women in treatment should be strongly discouraged from dealing with issues of childhood victimization, because exploring such issues is a late-stage recovery task.

What are the most important implications of this paper for the role of an outreach worker serving addicted women and their children? Note your observations below.

____

____

____

____

____

1.4 Learned Helplessness: Implications for Outreach

Learning Objectives

1. Discuss the concepts of learned helplessness and learned helplessness depression, as those concepts relate to Project SAFE clients.
2. Identify elements of clients' life histories that have led to the development of learned helplessness.
3. Identify ways in which this condition complicates treatment and outreach efforts.
4. Identify ways in which outreach workers can help women overcome learned helplessness and be empowered to recover.

A New Name for an Old Condition

You've probably seen it more times than you'd like to remember: A woman lives for years in conditions that cause her pain, deprive her of what she needs, and/or threaten her life. Even when she gets an opportunity to escape the nightmare, she lets the opportunity slip past her. She always has reasons for staying, but those reasons don't always make sense. What's really holding her back?

The concept of Learned Helplessness helps us understand this kind of decision pattern. When people—particularly children—are taught over and over again by their life experiences that they have no power to protect themselves, they tend to give up. Even if their circumstances change later in life, they're often unable to change their decision patterns. It's as if their self-protective powers were being held down by some unseen force. A study conducted in the early 1970s shows how this condition works.

In that study, researchers put a group of dogs into cages. Then the researchers gave a mild electric shock to the dogs through the metal floors of the cages.

The dogs all started barking and trying to escape. But after they'd been shocked repeatedly over a long period of time, they stopped barking and trying to escape. Instead, whenever they were given an electric shock, they lay down on the floors of the cages and cried. This continued even after the doors of the cages were opened and the researchers tried to coax or pull them out. When electric shocks were administered, the dogs still lay down and cried.Compare that pattern to the behavior of a client who is unable to leave her abusive paramour, even after you've shown her a way out. And what about the woman who can't seem to look for a job or a place to live, even though she's competent and she's been clean for a while? Your client might have a history of being very willful about alcohol and other drugs. But when she needs to protect herself or build a healthy life, it's as if she has no will to survive. This is learned helplessness depression.

1. Think of the women you've served as an outreach worker. What percentage would you say suffer from learned helplessness depression?

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2. What are some of the signs of this condition that you hear in your clients' words and see in their behavior?

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How Learned Helplessness Develops

Think of a small child with an adult whom the child loves and depends on for food, clothing, shelter, attention, play, etc. The adult is the child's source of authority, the one who decides what's right or wrong. If the adult says or does something that is abusive, how would the child know that the adult is breaking the rules? After all, the adult is the one who makes the rules. Many things that adults make children do are painful—going to the dentist, for example. How is the child to know that the abuse is any different?

As the abuse continues, the child learns that there's nothing she can do to stop the abuse or escape the situation. Often she's been told by the abuser that, if she tells anyone or does anything to try to escape, the abuse will get worse. And if she does try any of those actions, in most cases she isn't believed and the abuse does get worse. She gives up on the possibility of escaping the abuse, and retreats inside herself for comfort. She learns to dissociate—to pretend that she doesn't feel those intolerable feelings, and that her painful and humiliating experiences are happening to someone else.

The only way the child can tolerate the abuse is to believe that she has somehow caused it, by doing or being something bad. If she caused it, she must have some kind of power, even if it's just the power to be a bad person. So she learns to believe she's responsible and to blame herself, and the people around her do nothing to challenge that belief. In fact, they often tell her that she deserves to be punished, and that the punishment is a sign of their love. Toxic shame and guilt take hold in every area of her life. The more she's abused, the more guilty she feels.

What has the child learned from these experiences? What are the messages she's heard and believed? You have no rights. You have no say over what happens to you. Your power to make

decisions about your life has been taken over by someone else—it's not your power any more. You **have** no power. Nothing you can do will make it any better for you, and anything you try is likely to make it worse. No one can help you. No one will even believe you. You have no hope. It's your fault, too. It's because you're basically bad and worthless. Anyone who loves you will hurt you, because you deserve to be punished.

In adult life, she'll be attracted to people who mistreat her, because they seem familiar and because she doesn't believe she deserves any better treatment. She'll be afraid of, or angry with, people who try to help her. If she abuses her own children, she'll believe at the time that she's doing it because she loves them. But if she has abused or neglected her children, her shame and guilt will be so intense that she'll seek out people and experiences that will punish her for her actions. The abuse or neglect of her own children can become a way of keeping the guilt alive, making sure she never serves her "sentence" in full, no matter how much she suffers.

1. Think of a client you know well who suffers from learned helplessness. What was her life like when she was a child?

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2. What does this woman say or do that might make you think she believes she has no rights, no power, and no hope?

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3. What does she say or do that might make you think she believes she can't do anything right?

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   ____

4. What does she say that might make you think she blames herself for all the painful things that have happened?

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   ____

5. How does she punish herself—or let others punish her—for the shame and guilt that she believes is hers?

   ____

Challenges for the Outreach Worker

When a client's entire belief system is set against her success—at anything—it's hard to help her believe in herself. Her learned helplessness has paralyzed the part of her that's capable of believing in her potential. It doesn't help simply to say, "Go on, you can get an apartment! You can find a job! Just do it!" It would be like telling someone in a wheelchair to get up and run across the room. The more you expect of her before she's ready, the more shame and guilt she feels at not being able to meet your expectations, and the more she's convinced of her own worthlessness and uselessness.

1. Think of a client who doesn't believe she can help or protect herself. What words might you use to let her know that you really do understand how she feels?

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2. What words or actions might you use to let her know you believe in her?

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3. What parts of her personality or her behavior can you show her as evidence that she's capable and resourceful?

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Healing Learned Helplessness

Because learned helplessness is so deeply rooted, it takes a long time and quite a bit of care just to begin the healing process. Creating a safe atmosphere for healing is the first and most important part of that care. That's why your honesty, respect, fairness, consistency, and reliability are so important. Project SAFE may be the first safe place your clients have ever found.

Often clients have dissociated or blocked themselves off from their painful feelings, including anger and rage at the people who have abused them. When they were children, the numbness protected them from the worst part of their pain. Now that they're adults, the numbness locks the pain in so it can't be healed. You may have found yourself feeling anger on behalf of a client who feels little or no anger at the people who have abused her. It's as if you're carrying her anger for her, keeping it safe until it's safe for her to feel it herself.

When clients start to feel their anger and other unpleasant feelings, it's a sign that they're starting to get well. One mistake that traditional treatment programs make is to punish women for getting angry: "Control your temper of you're out of here!" That just reinforces the client's old pattern of burying her feelings. One of the reasons Project SAFE is so empowering is that women are allowed to feel their anger and encouraged to express it in appropriate ways.

When a client's anger does begin to surface, it may come up in the form of rage. That rage might not be directed at the people who are responsible for it. Instead, it might be directed at other clients, at people who remind her of the ones who abused her in her childhood, or at you. You can begin to help by understanding her anger for what it is: something natural and normal that she has to go through in order to get well.

Through your words and your example, you can teach her that it's okay to feel angry. It's possible to deal with the anger in constructive ways—even channel the energy of anger into actions that she wants or needs to take for her own well-being. You can also help her understand that she won't be helping herself—and she might be making her life a lot worse—if she reacts to the anger by hurting herself or others.

It's equally important to respect those times when she has to "shut down" for her own emotional survival. When she's feeling her negative feelings, you can help her process those feelings. But when she's out of touch with her feelings, that means it's not safe for her to feel them. Your best reaction is simply to "meet her where she is"—to work with whatever thoughts and feelings she's willing and able to give you at the time. That way she'll know it's safe to open up when she needs to open up, and it's safe to close down when that's what she needs.

As an outreach worker, you're in a unique position to help the client move from learned helplessness to empowerment. In the beginning, you may have to do things for her, as if she were a child. As time passes, you move into the role of doing things **with** her, giving her a

chance to try new things and learn new skills. Then you gradually remove your own efforts and gently but firmly guide her as she starts to take responsibility for her own life. You let her stretch her wings, but you stay available in case she needs to rest—or fall on her face.

The messages you're giving her are the exact opposites of the ones she learned as a child: You have rights. You have some say over what happens to you. You have the power to make decisions about your life. You can do things to make your life better. Some people can and will help you. Some people will believe you, and believe **in** you. You have hope. Like everyone else, you've made mistakes, but the abuse you've suffered at the hands of others is not your fault. You didn't cause it. People who love you don't abuse you. You don't deserve to suffer. You deserve to be happy and free.

1. What is it about you that helps women feel safe around you?

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2. What qualities in yourself would you like to improve so that your clients' safety will be improved?

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3. How do you feel when clients get angry? What do you say? What do you do?

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4. What are some things you can do to encourage women to deal with anger in constructive ways?

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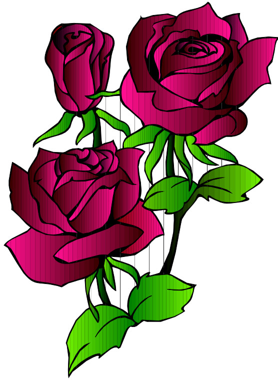
5. How do you feel when clients seem emotionally numb? What do you say? What do you do?

6. Re-read the paragraph about empowerment (the second-to-last paragraph, above). What's the hardest thing about that process for you?

7. There's a module on "Empowerment" later in this manual. Where else could you go for help or guidance in becoming more comfortable with the empowerment process?

8. What might you tell yourself that would make the empowerment process easier for you?

9. Of the healing "messages" that you give women through your work in Project SAFE, which ones seem most powerful in helping them recover?



Section 2.0
Becoming an Outreach Worker

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2.1 What Does an Outreach Worker Do?

Learning Objectives

1. Discuss some of the roles that many outreach workers play in their clients' lives, and identify the roles that you do or don't play in your position as an outreach worker.
2. Discuss some of the ways in which those roles might sometimes conflict with one another, even though you're doing your best to help your clients.
3. Discuss the three roles (or tasks) that are the most difficult for you because of who you are and what you've been through (or haven't been through) in your own life—or because of your work situation—and some possible ways of overcoming those difficulties.
4. Discuss the three roles in which you feel most effective and successful in helping your clients, and why these roles come naturally to you.

The Natural Birth of the Outreach Worker's Role

More than any other position in Project Safe, the outreach worker's role was created by the outreach workers themselves, based on client needs. When the project began, the outreach workers were not assigned to the intense treatment attraction and encouragement role that they play today. Their duties were supposed to begin when women entered treatment.

But the early outreach workers had little or nothing to do while they waited for the first clients to decide to accept treatment. So they started calling potential clients, giving them information and encouragement, and slowly and patiently proving that they could be trusted. Now most people involved in the project will tell you that the outreach workers' efforts are often the biggest reason women are able to enter and stay in treatment.

"You must be there when they hit bottom," said one outreach worker. "You must build a relationship so that in crisis they reach for you and not the drug. Hitting bottom doesn't necessarily mean change. When she hits bottom alone, she reaches for the drug and addiction continues. When she hits bottom and *I'm* there (representing hope), change is possible."

The Many Roles of an Outreach Worker

"I sometimes feel like what a seeing eye dog may feel like," said another outreach worker. "Sometimes they're just blind and that's all they can do, hold on to the back of your shirt and walk wherever you take them." Of course, the outreach worker's job is much more complicated than simply turning left here, right there, and stopping at red lights.

Here are some of the roles that Project SAFE outreach workers play in women's lives, and the things they sometimes need to do in those roles. These are taken from a series of interviews with outreach workers. Not every outreach worker plays every one of these roles or does every one of these things. Some host agencies have policies against having outreach workers perform some of these tasks. Some agencies have other staff performing some of these tasks instead of outreach workers.

As you read through this list: 1) Cross out any roles or tasks you don't do because your agency has a policy against them, because other people are assigned to them, or for any other reason; and 2) circle any roles or tasks that take up much of your time or energy. When you've finished reading, write in any of your roles or tasks that are missing from the list.

- **Irresistible Force:** When she's still resisting your visits or your efforts to get her into treatment, going back time and time again, letting her know that you're there for her and you're not going to give up on her, and wearing down her resistance with your patience and your belief in her.
- **Friend:** Listening, listening, listening; building trust by being honest, keeping your word, and sticking with the client; seeing her as an equal; not judging or looking down on her; not making excuses for her; understanding how hard it is for her; being there when she's scared, sad, and angry; laughing with her.
- **Cheerleader:** Encouraging her to keep trying even though she believes she can't do it; letting her be exactly who she is, but showing and telling her that you believe in her ability to be who she wants to be; celebrating her entry into treatment and her graduation from treatment; marking all the times she's done things right.
- **Mother/Nurturer:** Loving her even when you don't like her; giving her the kind of consistent caring that most clients' mothers weren't able to give them; showing her how proud you are of even her smallest successes.
- **Crisis Counselor:** Being there for her when she's hitting bottom, grieving a loss, going through a crisis, or losing control; being calm when she's falling apart; thinking of consequences and possible solutions when she can't; teaching her by example how to think of consequences and choose solutions; not taking it personally or showing your frustration when she yells at you, blames you for her problems, refuses to talk to you, refuses to let you in, or tries to manipulate you.
- **Role Model:** Telling her about some of the ways you've overcome problems in your own life; showing by your own example how to be a responsible, successful, clean, healthy, honest, positive, growing, learning, loving, caring, respectful, self-respectful, dignified human being.
- **Diplomat:** Helping family members learn how to respond appropriately and productively to her addiction and her behavior; knowing what to say and what not to say about the client to her family; helping the client understand the DCFS case worker and the case worker understand the client; maintaining smooth relations with DCFS, the court system, and other agencies; keeping the women from fighting with one another in transport, but instead teaching them to take their conflicts into group for processing.
- **Advocate:** Looking out for her rights and those of her children, and speaking up when

her rights or her children’s rights are being violated.

- **Monitor:** Looking for and pointing out safety problems in the home, and suggesting ways of solving those problems; taking urine drops; noticing signs of domestic violence and linking the client to shelters and people who can help; noticing and reporting to DCFS any signs of child abuse or neglect.
- **Chauffeur:** Picking up all of your clients and their children, taking the children to child care and the women to group; taking individual clients to accomplish important survival tasks that they can’t get to otherwise; keeping everyone in the vehicle safe even though some of them are emotionally, verbally, and physically out of control; keeping the vehicle in working order and getting things fixed before they break down.
- **Home Consultant:** Helping the client learn—or find resources to learn—how to clean her house, make a grocery list, buy groceries, get access to organizations that give away food, cook, care for her children’s hygiene, care for her own hygiene, and decorate her home with little or no money.
- **Housing, Transportation, and Educational Consultant:** Helping her find appropriate housing if she’s homeless or living in an unsafe place; helping her learn how to use the public transit system; helping her get bus tokens from service agencies; helping her find the right schools for her children and get her children’s paperwork processed; encouraging her to go back to school when she’s ready, and helping her find ways of doing that.
- **Medical Consultant:** Noticing signs of sickness or injury in the client and her children; telling her about “common-sense” home remedies when these are appropriate; helping her find and choose appropriate medical care; taking her and her children to the doctor or clinic for checkups and medical care, when that’s needed.
- **Recovery Facilitator:** Helping her understand her addiction, the importance of recovery, and the dangers of continuing to use; helping her understand what relapse is and why she doesn’t have to hide from you or beat herself up if she’s relapsed; introducing her to the self-help groups that address her needs and helping her understand what to expect in those groups and how to get the most out of them; giving her meeting schedules and helping her find safe transportation to them; taking her to meetings and introducing her to women with substantial clean time who might be good sponsors or role models.
- **Financial Consultant:** Helping her learn to understand the consequences of not paying bills, pay her bills on time, keep track of her money, save for emergencies, and apply to the appropriate agencies for financial help.
- **Record-Keeper:** Keeping a daily log of all activities with each woman; filling out billing forms on a timely basis instead of letting them all pile up at the end of the month; making to-do lists and sharing them with your supervisor; writing notes about anything you need from other staff; filling out all other forms your agency asks you to fill out.
- **Team-Player:** Meeting with your supervisor when it’s required or when you have a situation you need to talk about; attending weekly staffings with your supervisor, case managers, counselors, other outreach workers, and DCFS case workers; sharing information about your clients with other staff in order to keep staff members from being “played” against one another; showing clients a united staff who won’t be played against one another.

- **Teacher:** Leading group information sessions on personal care, child care, family issues, health and wellness, or stress management; linking clients with people who can help them improve their reading skills, including other clients who can act as tutors.
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- ____
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- ____
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Take a minute to look at all the roles and actions that are left on that list, even if you've crossed some off. It will probably be a very long list of things you already do or may be called on to do. These are all important roles and tasks. In some cases they make all the difference in a client's ability to get into treatment, make it through treatment, stay clean, or be an effective mother for her children. If you ever have any doubts about the importance of your role as an outreach worker, remember this list.

Role Conflicts

Read through those roles again, and the things that outreach workers do as part of those roles. As you read, pay attention to your "gut" feelings. If you're already working as an outreach worker, think of experiences you've had with each of these roles, and with combinations of roles. Have you ever experienced any conflicts between two or more roles that are part of your responsibilities as an outreach worker? If you're just starting your job, use your imagination to think of ways in which some of these roles might sometimes conflict with one another. Take this scenario as an example:

Denise is fairly new to the project and has little or no self-esteem. You've been trying to help her with that, and she's just starting to be able to trust you. She's is receiving interim services while on the waiting list to get into group, and you visit her once a week, or more often when it's necessary. You recently helped her straighten out a misunderstanding with her family and her DCFS case worker so that she could have unsupervised visits with her children, as was set forth in her court decree.

Today you went with Denise on her visit with her children, and you saw her neglecting her children's basic needs, including their safety needs. You suggested and modeled other ways of interacting with the children, and made a commitment to help her improve her parenting skills. She seemed ashamed of her skill level, said that she was willing to learn, but didn't seem to understand what you were saying. You left the situation with a strong gut feeling that her children wouldn't be safe left alone with her on those visits.

1. What roles have you been playing in Denise's life?

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2. Which roles, if any, might seem to be in conflict with one another; and what are some of the reasons for that conflict?

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3. How do you feel when you're expected to play these or other conflicting roles?

   ____

   ____

4. How do you think Denise feels if you're trying to play conflicting roles?

   ____

   ____

5. What, if anything, can you do to lower the level of conflict between the roles you need to play, become more comfortable with the conflict that exists, and/or get help in deciding how to handle the situation?

6. How might you handle the situation?

Most Difficult Roles

Of all the roles described on the list, name the three that are most difficult for you to play, and tell what it is about you, your experience, or your situation that makes those roles difficult.

First Difficult Role:

Second Difficult Role:

Third Difficult Role:

For each of the difficult roles, what help can you get in making it easier to learn to play that role, or—if that doesn't work—in finding a way to share the burden of that role so you're not facing it alone?

Help for the First Role:

Help for the Second Role:

____

Help for the Third Role:

____
____
____

Most Successful Roles

Of all the roles on the list, name the three that you believe you play most successfully, with the strongest positive effects on your clients' lives and recovery. For each of the three roles, tell what it is about you, your experience, or your situation that makes you most successful in that role. If you're new to outreach, choose the roles that you believe will come most easily to you.

First Successful Role:

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____

Second Successful Role:

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____

Third Successful Role:

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Congratulate yourself on the incredible job you're doing juggling all these roles and tasks! If you're just starting out, you can be proud of your commitment and courage in taking this job. Please don't be intimidated by the wide variety of roles and duties. There are supervisors and other outreach workers—at your site and other sites—who can help you through the challenges of the early days.

2.2 Outreach: What Does it Take?

Learning Objectives

1. Understand and discuss, from the client's viewpoint, the most important qualities for an outreach worker to have.
2. Honestly assess your current level of progress on the ideal qualities for an outreach worker.
3. Identify people in your life who are strong in the qualities you most need to work on, so that they can serve as mentors for you.
4. Discuss some of the ways in which experience of addiction and recovery can increase or decrease an outreach worker's effectiveness, and steps that outreach workers can take to make sure their own history doesn't complicate or endanger the outreach process.

What Does it Take?

If you've just read the list of outreach worker roles in the last module, you might feel like effective outreach requires a saint, a perfect person, or a super hero. Well, it doesn't. There are plenty of excellent outreach workers who sometimes make mistakes, doubt themselves, and fall short of their own and their clients' expectations. You'll be looking a little more closely at realistic expectations a little later in this manual. In the meantime, look at the ideal—not as something to feel "less than," but as a light to guide you.

A Client's-Eye View

For a moment, please forget who you are, where you are, and what your life is like right now. Put your mind and your emotions in the place of those of a client. If you're a former client—or someone else who's had quite a bit of pain and problems in her life—that experience will help you identify. If not, you can call on your imagination, or on your empathy for your clients.

You're 20 years old. You grew up in a housing project, in an apartment with your alcoholic mother, your grandmother, and your three uncles. Your mother sometimes beat you when she was in blackouts. You were first sexually abused when you were eight, by one of your uncles, and the abuse continued until you were 13. At that point you were pregnant, and you admitted to your mother who the baby's father was. Neither she nor your grandmother believed you, and they kicked you out of the apartment. You never went back to school after that. You blamed yourself for the abuse, and for having been kicked out.

You've been drinking since you were nine, and smoking crack cocaine since you were 16. You had your first baby at age 14. You have three children, all by different fathers, placed in separate homes by DCFS. You love your children and you miss them, but you

wouldn't have the first idea how to take care of them. Sometimes you live in shelters, sometimes with boyfriends, sometimes in abandoned buildings, and sometimes on the street.

You don't remember ever feeling good about yourself or ever trusting anyone. Anyone who was ever nice to you turned out to have some kind of angle, something they wanted from you. You came to expect that, very early. You've always jumped between doing what you thought people wanted you to do and lashing out in uncontrollable anger. You're convinced that you're crazy, and sometimes you think it's because you're basically evil and worthless. You can't picture anyone really loving you.

You've been in contact with social service agencies since your first pregnancy, and you've had many different case workers and dealt with personnel from a number of agencies. Most of them seemed to be judging you and seeing you as lower than them, even if they didn't say anything about it. Part of you agreed with them. There were a couple who were nice, but they were pretty stupid and easy to fool. They didn't last long. Either they quit their jobs or their programs stopped being funded, or you never knew what happened to them—they just went away.

You've tried to get clean by yourself a few times, but you've relapsed pretty quickly and it's always made you feel even worse about yourself. The idea of treatment and recovery groups terrifies you. You can picture everyone judging you and putting you down and looking at you like you're a piece of dirt. Now a woman has called you at the shelter, saying she's an outreach worker from Project SAFE, a treatment program for women. She says DCFS has made a referral on you, and she's coming in this afternoon to talk to you. You said okay, but the idea has brought back quite a bit of fear and anger about all the people who have said they were going to help, but really just made you feel worse about yourself, then abandoned you.

What qualities would you want and need this outreach worker to have if she's going to be able to help you, and how would you want her to treat you?

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Now take a minute to come back to yourself. You're not that client; you're an outreach worker with skills and talents and resources to help her do her work. Think about your life as it is today, your friends and co-workers, your family, your interests, your hopes, and your dreams.

Now look at the description you wrote of the outreach worker that the client would like to meet. Is it a description of you? Which of those ideal qualities do you already have, and which of those behaviors do you already show?

____

____

What are some of those ideal qualities and behaviors that you'd like to work on and improve in your own work?

____

____

What people, materials, activities, and other resources do you know that could help you work on developing those qualities and behaviors?

____

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What Some Outreach Workers Say

Even long-time veterans of the outreach role say that their job takes quite a bit of skill and flexibility. "You have to try to put them [the clients] at ease from the beginning, not go in and be boisterous and demanding," said one outreach worker. "Use some compassion. Try to assess the situation. Outreach is a versatile type of job. You have to change your moves to fit the particular person."

"When you go into their environment and you can't look around because things may be out of place, or things may be crawling, you can't focus on that," said another. "You just have to focus on the client, because they know if you're uncomfortable. They will sense that right away."

"We have to stay focused—like a guided missile. We have to sort through all the chaos of this woman's life and keep the focus on treatment and recovery."

The process of drawing a woman into treatment is often little more than a process of wearing down her resistance. That's where the persistence comes in. "They get to the point where they want to get you off their back," said one outreach worker. "They just surrender."

The intensity of the outreach worker's giving and nurturing requires that the worker also be receiving nurturing in other areas of life. "In order to be able to give away something, you have to have something to give away. If you're not being spiritually fed, it's hard." (See the module on "Stress, Strain, and Strategies of Self-Care.")

Self-Assessment of Progress

The following is a list of ideal qualities of an outreach worker that came out of a series of interviews with outreach workers and clients. In the middle column, rate your present level of progress on each quality from 0 to 10. Zero means "I don't have that quality at all yet," and 10 means "That quality comes naturally to me, and I show it consistently."

Writing a zero doesn't mean you'll never get that quality; it just means you haven't had the right conditions to develop it. Writing a 10 doesn't mean you're bragging; it just means you were born or raised with that quality or you've worked very hard on it.

In the line in the right-hand column, write the name of someone in your life who is strong in that quality. It might be a co-worker, a friend, a family member, a teacher, or someone else you can contact. You can use the same name for more than one quality, or for as many as you like. There are a few blank lines at the end of the list, so you can add qualities that are missing from the list.

Quality	Present Level of Progress (0-10)	Person Who Has That Quality
Knowledge of addiction and recovery	____________	____________________________
Knowledge of treatment	____________	____________________________
Freedom from drugs and alcohol	____________	____________________________
Tolerance for relapse	____________	____________________________
Knowledge of dual disorders	____________	____________________________
Knowledge of drugs and their effects	____________	____________________________
Resolution of major childhood issues	____________	____________________________
Feeling of equality with the client	____________	____________________________
Acceptance of people as they are	____________	____________________________
Sense of humor	____________	____________________________
Honesty with gentleness and care	____________	____________________________
Unconditional love	____________	____________________________
Street smarts	____________	____________________________

Quality	Present Level of Progress (0-10)	Person Who Has That Quality

Quality	Present Level of Progress (0-10)	Person Who Has That Quality
Trust, but not blind trust		
Knowledge of yourself and your true needs		
Ability to cope with others' anger		
Ability not to take things personally		
Openness to many ways of doing things		
Openness to many different personalities		
Sense of spiritual connection and trust		
Tolerance for dirty or messy environments		
Enthusiasm		
Easy-going disposition		
Persistence		
Patience		
Ability to forgive yourself		
Ability to forgive others		
Ability to keep information confidential		
Ability to see the simple in the complicated		
Compassion and empathy		
Strong will and determination		
Desire to be with people		
Good listening skills		
Good communication skills		
Ability to simply be present		
Respect		
Awareness of "gut" feelings and instincts		
Flexibility		
Good problem-solving skills		
Ability not to show fear		
Ability not to show anger		

Quality	Present Level of Progress (0-10)	Person Who Has That Quality
Common sense		
Ability to “say it straight”		
Ability to resist manipulation		
Non-threatening personality		
Ability to focus on the client		
Diplomacy		
Willingness to see to your own needs		
Responsibility		
Dependability		
Ability to treat different people differently		
Integrity		
Ability to see through lies		
Loyalty tempered by realism		
Fairness		
Tough love		
Ability to set limits and protect boundaries		
Vision of the person behind the illness		
Ability to re-parent the client		
Ability to juggle many roles		
Ability to confront respectfully		
Bold faith		
Understanding		
Deep commitment		
Respect for the client’s turf		
Respect for the client’s culture		
Gratitude		
Instinct for when to talk or be silent		
Sense of identification with the client		

Ability to be yourself with the client	___________	_________________________
Desire to be part of a team	___________	_________________________
Willingness to learn	___________	_________________________
Willingness to do paperwork on time	___________	_________________________
Ability to take criticism and improve	___________	_________________________
______________________________	___________	_________________________
______________________________	___________	_________________________
______________________________	___________	_________________________
______________________________	___________	_________________________

Now look at the qualities in which you rated your progress at 5 or below. Make a list of the people whose names you've written next to those qualities.

__________________________________	__________________________________
__________________________________	__________________________________
__________________________________	__________________________________
__________________________________	__________________________________

These people would make good mentors for you—examples and sources of encouragement in developing the qualities you need for your work. You can make a commitment to spend more time with these people, and even ask them how they developed these qualities.

Experience of Addiction and Recovery

Many outreach workers are recovering from chemical dependency. Others have no addiction history of their own, but they've been close to someone else's active addiction—perhaps that of a parent, a close friend, or a significant other. They, too, may be going through a recovery process for the effects of living with another's addiction.

This first-hand experience of addiction and recovery can add to an outreach worker's effectiveness. In some cases, though, it can also complicate the outreach process and pose some dangers to the outreach worker and to the client.

What are some ways in which being in recovery might make an outreach worker more effective in reaching and helping women?

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What are some ways in which the outreach worker's addiction and recovery history might complicate the outreach process?

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What are some possible dangers to the outreach worker?

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What are some possible dangers to the client?

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Most Project Safe sites set a minimum sobriety time (between one and four years) for outreach workers who are in recovery. This is to give people time to get stable in their recovery, work through their early recovery issues, and get as far as possible in facing and managing the effects of the painful circumstances in their past lives. It also makes it less dangerous for them to go into environments where alcohol and drugs may be right there in plain sight and scent, triggering cravings.

If people don't have enough recovery time and healing behind them, they sometimes project their "stuff" onto others who are trying to recover. They can start believing that others should recover exactly as they did, and interpreting others' problems as if they were exactly like their own. This makes it hard for clients whose needs and personalities are different from those of their outreach workers.

People who haven't had enough recovery time to heal their childhood wounds often find the pain and chaos of clients' lives a trigger for their own intense pain and fear. This can happen no matter how good their recovery program may be. Sometimes it takes many years in recovery before it's safe for these issues to surface and be healed.

What kind of "stuff" can an outreach worker who has a history of addiction and recovery—or unresolved issues from living with another person's addiction—bring to work that can interfere with effective service relationships with clients?

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What are some steps that outreach workers in recovery can take to make sure their history is only

an asset to the outreach process, and not an obstacle or a danger?

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2.3 Early Fears

Objectives

1. Identify and separate the major types of fears that are common to new outreach workers (safety-related fears, fear of the client, fear for the client, and fear of failure).
2. Accept a respectful attitude toward safety-related fears and refer to the module on Safety Tips.
3. Discuss some of the ways in which the client's emotional outbursts or "shutting down" can be intimidating, and ways of bypassing and overcoming that intimidation.
4. Discuss some of the legitimate fears for the client's or her children's safety and well-being that outreach workers face, and ways of living with those fears.
5. Discuss the fear of personal failure as an outreach worker, and ways of functioning in spite of that fear and eventually overcoming it.

Divide and Conquer

Most jobs hold some fear in the early days. It makes sense that a job like outreach, with its dangers and its unknown elements, would sometimes be particularly scary to new workers. This module is about understanding and dealing with those early fears.

One of the reasons fear can have such a powerful hold on us is that many unrelated fears often cluster together and feel like one huge, insurmountable fear. We feel overwhelmed by this fear because it's so hard to understand. It feels like one kind of fear one minute, and another kind the next. Pretty soon it feels as if we're afraid of everything.

So the first step in coping with fear is to sort it out, to separate and identify all the different fears that are at work. Then we can decide how to cope with each fear based on what it is and where it comes from. This module addresses separately the four types of early fears that outreach workers have identified in their interviews:

- safety-related fears
- fear of the client's behavior and emotional force
- fear for the client's or her children's well-being
- fear of failure as an outreach worker.

Safety-Related Fears

These are the most common fears—and very important ones. Many clients have violent tempers and live in violent situations, within violent neighborhoods. Many outreach workers describe the fear that goes along with a trip into public housing projects, or the fear of "Going up to the door, not knowing what's behind the door."

You need to read and work the module called "Safety Tips for Outreach Workers." Raising your level of safety will lower your level of fear, along with your level of danger. But the most important way to respond to safety-related fears is to pay attention to them. Respect them. They might save your life.

If your gut instinct is telling you a situation isn't safe, you need to get out of that situation. In the words of one supervisor, "I'd strongly encourage the outreach workers to trust their instincts. If you're feeling unsafe, leave. We'll go back later." You need to talk to your supervisor about your fears, talk to other outreach workers, study all the safety tips, and obey your instinct for self-preservation.

How do you know when you're feeling a safety-related fear? What are some of the thoughts you have at those times?

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What are some of the physical feelings you get when you're afraid?

____

____

What do you usually have an urge to do when you're afraid?

____

____

What do you actually tend to do?

____

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Some people have a tendency to "freeze up" when they're in physical danger, so they can't move or protect themselves. Others tend to ignore their fears and take dangerous risks. If you tend to do either of those things, what steps can you take to make sure you don't get into those situations alone, and to make sure your co-workers know what to expect of you?

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Fear of the Client's Behavior and Emotions

Many people find other people's strong and unpredictable emotions intimidating. They don't know what to do, what to say, how to respond, how they should feel, what's expected of them, or what's going to happen next. They feel as if the situation is out of control. It might remind them of situations in the past when emotions went out of control and they were hurt. It might bring up strong emotions of their own that they'd rather not think about or deal with.

People can also feel intimidated when others are silent, resistant, withdrawn, or emotionally "shut down." They feel as if it's their responsibility to break through the resistance, but it's not working. In either of these cases—if a new outreach worker is dealing with a client's emotional outburst or shut-down—the outreach worker's sense of responsibility for the client's emotions can make the situation particularly frightening.

What kinds of behavior and emotions (or lack of them) have you found most frightening or intimidating in clients and/or other people you've known?

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What might it be in your personality or your history that makes these emotional states hard to deal with?

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What ways have you found most helpful in getting through these rough spots?

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Unlike the safety fears described above, these are not the kinds of fears you can escape by going away and coming back later in the day with a co-worker. It's a natural part of the client's disease to be hostile, resistant, unpredictable, and out of control. These are fears you simply need to overcome, using whatever resources are available to you.

"If you're always afraid, you can't be an outreach worker," said one woman. "In the beginning it's just natural. But if you can't overcome the fear, then I think it's best to try to do something else, because you can't drive around scared." Outreach workers and supervisors recommend talking to your supervisor, and to other outreach workers, about your fears. Chances are they had the same fears in the early days. They can give you some perspective on your fears and hope for their resolution. They can also tell you what they did to overcome their fears.

Sometimes new outreach workers feel uncomfortable around clients whose ethnic and cultural backgrounds are different from their own. A client's behaviors and emotions might be normal in

her own culture, but in the outreach worker's culture they might signal danger or hostility. If you work with clients whose cultural background is different from your own, it's your responsibility to learn as much as you can about their culture. That way you can separate culturally normal behavior from signs of trouble.

If your fears are being intensified by your unresolved childhood issues, then you'll probably need therapy to work through those issues. If you come into the situation carrying your own baggage, you won't enjoy your work and you'll be cheating the client. You won't be seeing her needs clearly, because you'll be seeing her through the eyes of your own past.

While you're working on healing your fears, you still have to function in the outreach role. That involves learning to manage the fears that are still bothering you. There are two parts to managing these emotional fears. One is simply going ahead and doing what you need to do even though you feel afraid (again, we're not talking about safety-related fears here). The other is learning not to show the fear. "You can't appear scared when you come onto their turf, because they sense that," said a seasoned outreach worker. "If they feel you're scared, they'll bluff you, bully you—big time."

Another outreach worker told the story of a client who lived in public housing—below her family and above a drug dealer's apartment. When the outreach worker first came to her home, the client screamed and yelled and threw things on the floor, telling her to get out. The worker had to hide the fear she was feeling so that the client wouldn't believe she could chase her away. Then when they left the building, the client's personality changed completely. She grew calm and receptive and agreed to enter treatment. She simply had to put on a show of resistance in her apartment, to keep her neighbors from knowing she was going along with the program.

What other examples have you seen of clients using resistance and emotional force as a kind of "bluff" to hide or cope with their fears?

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How might it help you if you looked at many of their emotional displays this way?

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Fear For the Client's or Her Children's Well-Being

Unfortunately, these fears are often well founded in reality. Many clients live on the streets or in violent housing projects; with violent paramours; and/or with a long history of self-destructive, abusive, neglectful, and/or violent behavior. Many have been exposed and continue to be exposed to HIV. Few clients have adequate preventive health care. Even clients who have adequate housing are living very close to homelessness. One relapse could easily eat the next month's rent money and result in eviction. If you didn't consider these very real possibilities, you'd be in denial.

What are some of your strongest fears for your clients' or their children's safety?

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____
____

What resources do you find most helpful in coping with those fears?

____
____
____

Describe how you felt or might feel if a client . . .

. . . talked to you about suicide:

____

____

. . . hit or screamed at her children in your presence:

____

____

. . . chose to go home to a paramour who was angry and had a history of abusing her?

____

____

In your experience, what's the best way to deal with those kinds of situations if you're not sure what to do or how to respond?

____

____

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If these kinds of fears are difficult for you to manage, please read the module called "Empowering vs. Enabling." It will give you some help in responding to clients' self-destructive behavior. But as long as you care about a client, these kinds of issues are going to raise some fear in you, and you're going to grieve her pain and the damage to her life. The module called "Self-Care" can be helpful in that process.

What other resources are in your life that can help you cope with this "down-side" of caring for another human being?

____

Fear of Personal Failure

Compared to the outreach worker's fear for the client's well-being, the fear of failure might seem like a selfish and petty fear, but it's not. Everybody has it. We all want to be good at what we do, be successful, and be recognized for that success. What's one thing that has happened (or might happen) in your work that you might respond to by feeling as if you had failed?

Look at this situation more closely. How much of it is your personal failure, and how much is a combination of circumstances beyond your control?

Many new outreach workers say they're afraid of low census─of having the clients not show up for treatment. One woman spoke about the summer of her first year as an outreach worker. Her program had been successful for months and months, graduating many women. Then the summer came, and they couldn't get anyone to stay more than two weeks. "And I would swear it was something that we weren't doing, or something that we were doing that was making them uncomfortable." Finally her supervisor called her in. After letting her talk and cry for a while, the supervisor simply asked, "Who wants to go to treatment in the summertime?"

That began the outreach worker's education in separating responsibilities. "I can't cure anybody─I can only support them and be there for them while they cure themselves," she said. The best defense against real failure is more education, more training, more guidance, and more support for your efforts. Beyond that, fear of failure is normal. Like a small dog yapping around your feet, the less attention it gets, the less likely it is to bother you.

Resources

A good resource for coping with fear in general is a book by Susan Jeffers called *Feel the Fear and Do it Anyway* (New York, Fawcet-Columbine, 1987).

2.4 Personal Style

Learning Objectives

1. Discuss the importance of being yourself in the outreach role and finding your own style and approach to outreach work.
2. Discuss some of the elements of an outreach worker's style (dress, accessories, tone of voice, body language, etc.) and what those elements might "say" to a client.
3. Discuss the personal style that you've developed in your life.
4. Identify the elements of your style that you've changed or modified—or might change or modify—to make it easier for your clients to be comfortable with you.

Being Yourself

The subject of an outreach worker's personal style can sometimes raise conflict because there are two very important considerations at work:

1. It's important for the outreach worker to be herself, both for her own comfort in the job and for her clients' comfort in working with her.
2. In most cases, the more your personal style sets you apart from the client, the harder it will be for her to trust you and see herself in you.

The first of these considerations was raised by a supervisor. "I just think that they [outreach workers] need to be comfortable in whatever approach they use, because the clients are so testy, and if they can sense that you're not comfortable in what you're doing, then they're going to push, push, push."

"Everybody has their own way of doing things, because what seems easy for you might be complicated for me. So you have to gradually get your own style, your own way of doing things."

But the second consideration can't be forgotten either. "Be respectable," said one outreach worker. "Be a role model for them. But the minute you dress up in a dress and stockings and look professional, they draw back. It's like we're now up here and they're down there. But if you wear the same attire that they're wearing—neat and clean—it's like we're buddy-buddy."

Another outreach worker brought up the importance of fitting into the environment in order not to make the client—and her involvement in the project—stand out. When you leave the building with a woman, it's better to look like her friend than her outreach worker. It protects her privacy.

In terms of personality, some outreach workers prefer to start out by matching the client's way of relating. "I'm very flexible," said one. "I kind of like go wherever that person is as far as her personality and her attitude." If the client is "soft," the worker takes a softer approach. If the

client is “hard,” the worker comes on a little harder.

Elements of Personal Style

Put yourself once again in the client’s place. For each point of style listed below, write a little about what that element of style tells you, the client—about the outreach worker, about yourself, about her attitude toward you, about what you can get away with, etc. Also note if any of these elements might remind you of past experiences with social service personnel, with the using culture, etc. Of course, not every client will see them the same, so look at them as most of your clients might tend to look at them.

Big words and complicated sentences:

____

____

Clean jeans and jacket:

____

____

Fearful looks and a hesitant tone of voice:

____

____

Flashy jewelry, a big diamond engagement ring, and a leather coat:

____

____

Always keeping quite a bit of distance between her and you:

____

____

Stern “mama” looks and an aggressive tone of voice:

____

____

Simple words, some street talk:

____

____

Standing or sitting very close to you when there’s room to spread out:

____

____

Worn-out jeans with holes in them:

____

____

A clipboard with a yellow pad on it:

____

____

A simple dress and flats:

____

____

A matter-of-fact tone of voice:

____

____

Heels and a tight mini-skirt:

____

____

Hair that hasn't been combed:

____

____

Lots of swearing and sexual language:

____

____

Laughing and playing with your kids:

____

____

Making a lot of jokes:

____

____

Rolling her eyes when she walks into your apartment:

____

____

Telling you many very personal things about her life and experiences:

____

Speaking very slowly and carefully, exaggerating the way she pronounces her words:

A gorgeous, expensive suit:

Lots of sad looks and expressions of sympathy:

Fast, clipped tone of voice, very little emotion:

Again, not every client is going to react the same to any one of these elements of style. But it's important to get in the habit of looking at personal style from the client's point of view and seeing how it might affect your relationship with her.

Your Personal Style

Describe the personal style you've developed over the years:

Describe your style of dress and your hairstyle:

Describe your typical body language (in non-sexual situations):

Describe your general tone of voice when you're not upset:

Describe your usual facial expressions when you're not upset:

Describe your usual facial expressions when you are upset:

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____

Describe the language that you use in most conversations:

____

____

Describe your sense of humor:

____

____

Modifying Your Personal Style

What elements of your personal style do you tend to change when you're with clients? If you're new to outreach, what elements of your style do you think you might try changing?

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Are there any elements of your personal style that others thought wouldn't work with clients, but that ended up working well anyway?

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Are there any ways in which you find it hard to be yourself around clients?

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Who do you know who could help you work through those issues?

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____

One final note: As you probably already know, personal style isn't something you can figure out intellectually and simply "decide" to do. Some elements of your style aren't going to change no matter who doesn't like them. And sometimes it's hard to be yourself even though you know that would be the best way to go. Your intuition, combined with information from your supervisor, your co-workers, and your clients, may be your best guide.

2.5 Learning About Addiction and Recovery

Learning Objectives:

1. Locate the major substance abuse-related training resources in Illinois.
2. Describe the process of worker certification within the substance abuse prevention and treatment field.
3. Identify key addiction-related texts.

What Do You Need To Learn?

Working effectively as an outreach worker requires a wide range of knowledge and skills. This includes an understanding of:

- the nature of addiction and the needs of addicted women entering treatment;
- families and communities;
- treatment, and the role that outreach services play in the treatment and aftercare process;
- recovery- and community-based resources that can support women in their long-term recovery; and
- the ethical and legal issues that can arise in the delivery of outreach services.

No outreach worker has all of this knowledge when he or she begins working. Working in the field is a process of ongoing education. In this module we will review the kinds of strategies and resources that can help you actively seek and make the best of this educational process.

Reading

<u>AIDS and Substance Abuse</u> (including approaches to AIDS case management)

Land, H. Ed. (1992). *AIDS: A Complete Guide to Psychosocial Intervention.* Milwaukee, WI: Family Service America, Inc.

Leukefeld, C., Battjest, R. and Amsel, Z. Eds. (1990). *AIDS and Intravenous Drug Use.* New York: Hemisphere Publishing.

<u>Case Management</u>

Moxley, D. (1989). *The Practice of Case Management.* Newbury Park: Sage.

Raiff, N. and Shore, B. (1993). *Advanced Case Management.* Newbury Park: Sage.

Counseling

Small, J. (1990). *Becoming Naturally Therapeutic: A Return to the True Essence of Helping*. Austin, TX: Eupsychian Press.

Zimberg, S., Wallace, J., & Blume, S. (1985). *Practical Approaches to Alcoholism Psychotherapy.* New York: Plenum Press.

Ethical Issues in Addiction Treatment (and Outreach)

Bissell, L. And Royce, J. (1994). *Ethics for Addiction Professionals.* Center City, MN: Hazelden.

White, W. (1993). *Critical Incidents: Ethical Issues in Substance Abuse Prevention and Treatment.* Bloomington, IL: Lighthouse Institute.

History of Addiction and its Treatment

Musto, D. (1968). *The American Disease: Origins of Narcotic Controls.* New Haven: Yale University Press.

Illinois' Response to the Needs of Addicted Women

White, W. (1990). *Project SAFE Program Handbook.* Springfield, IL: Illinois Department of Children and Family Services.

Introductory Textbooks

Brecher, E. (1972). *Licit and Illicit Drugs.* Boston: Little Brown and Company.

Kinney, J. and Leaton, G. (1991). *Loosening the Grip: A Handbook of Alcohol Information*. St Louis: Mosby.

Orientation to Addiction-Related Mutual Aid Groups

Alcoholics Anonymous (1955). New York City: Alcoholics Anonymous World Service Office.

Covington, S. (1994). *A Woman's Way Through the Twelve Steps.* Center City, MN: Hazelden.

Kurtz, E. (1979). *Not God: A History of Alcoholics Anonymous.* Center City, MN: Hazelden.

Kirkpatrick, J. (1986). *Goodbye Hangovers, Hello Life.* New York: Ballantine. (Description of the Women for Sobriety Program)

Relapse Prevention

Gorski, T. and Miller, M. (1982). *Counseling for Relapse Prevention.* Independence, MO: Herald House/Independence Press.

Special Needs of Addicted Women

Kasl, C. (1992). *Many Roads, One Journey: Moving Beyond the Twelve Steps.* New York: HarperCollins.

Roth, P. (1991). *Alcohol and Drugs are Women's Issues.* Metuchen, NJ: The Scarecrow Press.

Roman, P.M. (1988). *Women and Alcohol Use: A Review of the Literature.* Rockville, MD: U.S. Department of Health and Human Services.

Sandmaier, M. (1980). *The Invisible Alcoholics: Women and Alcohol Abuse in America*. New York: McGraw-Hill.

White, B. and Chaney, R. (1993). *Metaphors of Transformation: Feminine and Masculine*. Bloomington, IL: Lighthouse Institute.

Substance Abuse and its Treatment in Communities of Color

Trimble, J, Bolek, C. And Niemcryk, S. (1992). *Ethnic and Multicultural Drug Abuse.* New York: Haworth Press.

Williams, C. (1992). *No Hiding Place: Empowerment and Recovery for our Troubled Communities.* New York: HarperCollins.

Inservice Training

Most addiction treatment agencies provide regularly scheduled inservice training sessions to build the knowledge and skills of their direct service workers. We recommend that you actively participate in these sessions, and that you also take two more steps to get the most from these sessions: First, take notes on key points from each session; and second, keep a file of all your inservice training notes and handouts for future reference. This can be the beginning of your professional library. You can build that library through the years, and revisit it when particular issues or problems arise.

Outside Training

For the past decade, DCFS and DASA have sponsored special training sessions for people who work with addicted women who have histories of neglecting or abusing their children. Announcements of these trainings are sent to all funded women's treatment programs in Illinois. Be sure to tell your supervisor that you're interested in attending these training sessions.

There are other training resources that may increase your effectiveness as an outreach worker.

These resources can also prepare you for other roles in the addiction treatment field, if you're interested in pursuing them. Listed below are some of the addiction-specific training resources in Illinois and the contact person for each.

Academic and Clinical Training Programs

Dr. Joseph Troiani
Adler School of Professional Psychology
65 East Wacker Place, Suite 2100
Chicago, IL 60601
312-201-5900

Bill Green
African American Communiversal Project
P.O. Box 2783
Country Club Hills, IL 60478
708-798-6880

Rosemary McKinney or Frank Salvatini
College of DuPage
Human Services Program
22nd & Lambert Streets
Glen Ellyn, IL 60137
708-858-2800 Ext. 3050

Linda Wetherbe
College of Lake County
Human Services Program
19351 West Washington Street
Grayslake, IL 60030
708-223-6601 Ext. 2536

Director
Grant Hospital
Clinical Training Program for Addictions Counselors
550 West Webster, SE
Chicago IL 60614
312-883-3905

Billie Terrell, Acting Chairperson
College of St. Francis
Counselor Training Program
500 N. Wilcox St.
Joliet, IL 60435
815-740-3418 or 3360
815-740-3460

Kenneth P. Leisch
Danville Area Community College
2000 East Main Street
Danville, IL 61832
217-443-1811

Douglas Fraley
Elgin Community College
Human Service Department
Community College District #509
1700 Spartan Drive
Elgin, IL 60120
708-697-1000

Dr. Cheryl Mejta
Governor's State University
Addictions Training Center of Illinois
Governors Hwy., University Parkway
University Park, IL 60466
708-534-4911

Jeffrey Shore
Harold Washington College
Alcoholism & Substance Abuse Program
30 East Lake Street—Room 702
Chicago, IL 60601
312-553-6080

Illinois School of Professional Psychology
20 Clark St.
Chicago, IL 60602

312-201-0200

John Burian

Moraine Valley Community College
10900 South 88th Avenue
Palos Hills, IL 60465
708-974-4300

Felicia Dudek
National Lewis University
Alcohol & Substance Abuse Program
2840 Sheridan Road
Evanston, IL 60201
708-256-5150

Mary Ann Kubiak
Prairie State College
202 South Halsted
Chicago Heights, IL 60411
708-756-3110

Legia Ozeki
St Augustine College
1333 West Argyle
Chicago, IL 60640
312-878-8756

John Benshoff
Southern Illinois University
Rehabilitation Institute
Carbondale, IL 62901-4609
618-536-7704

Abdul Mannan
601 James Thompson Boulevard
East St. Louis, IL 62201-1129
618-583-2550

Thomas Delegatto
Triton College
Basic Addiction Counseling Program
2000 Fifth Avenue H-Building
River Grove, IL 60171
708-456-0300 Ext. 3428

Susan Scrimshaw
University of Illinois at Chicago
School of Public Health
Office of Dean
2121 W. Taylor St.
Chicago, IL 60612
312-996-6620

Joan Flanagan
Waubonsee Community College
Route 47 at Harter Road
Sugar Grove, IL 60554
708-466-4811 Ext. 467

Training programs that provide workshops and seminars for personal/professional development and for maintenance of Continuing Education Units (CEUs) for certification:

Jan Gomien
Academy of Addictions Treatment Professionals (AATP)
2300 Willemore
Springfield, IL 62704
217-787-9321

Gateway Training Academy
St. Louis, MO
314-421-6188

Susan Basile, Coordinator
Continuing Education
Haymarket House
Summer Addictions Institute
120 N. Sangamon
Chicago, IL 60607
312-226-7984

Irene Gainer, Executive Director
Illinois Alcohol and Drug Dependence Association
Annual Conference
937 South 2nd Street
Springfield, IL 62704
217-528-7335

Bill Johnson, Director
Illinois Alcohol and Other Drug Abuse Professional Counselors Association
1305 Wabash, Suite L
Springfield, IL 62704
800-272-2632

Michael Moran
Interventions
2221 W. 64th St.
Woodridge, IL 60517
708-968-6477

Randall Webber
Lighthouse Institute/Chestnut Health Systems
720 West Chestnut Street
Bloomington, IL
309-827-6026
Internet: www.chestnut.org

Dr. Robert Hotes
Prevention First, Inc
2800 Montvale Drive
Springfield, IL 62704
217-252-8951

Getting Certified

You might want to work toward getting certified as you build your education, training and work experience in the substance abuse treatment field. In Illinois, certification of workers in the field is administered by the Illinois Alcohol and Other Drug Abuse Professional Certification Association—commonly known as IAODAPCA.

IAODAPCA provides certification under the following classifications:

Provisional Alcohol and Other Drug Abuse Counselor
Certified Alcohol and Other Drug Abuse Counselor
Certified Reciprocal Alcohol and Other Drug Abuse Counselor
Certified Supervisor Alcohol and Other Drug Abuse Counselor
Certified Master Alcohol and Other Drug Abuse Counselor
Certified Assessment/Referral Specialist
Certified Alcohol, Tobacco and Other Drug Abuse Preventionist
Certified Senior Alcohol, Tobacco and Other Drug Abuse Preventionist

Certifications are granted based on a combination of qualified work experience, education, training, and supervision. The certification processes are slightly different for different classifications, but in general you'll need to prepare a portfolio application, pass a written test, and complete an oral case presentation. You can get information on application procedures and costs by writing or calling the Illinois Alcohol and Other Drug Abuse Professional Certification Association, 1305 Wabash Ave., Suite L, Springfield, IL 62704 (800-272-2632).

Journaling

Before closing this module on professional development resources, we'd like to offer one more suggestion that many people have found very helpful in enhancing their personal and professional development as outreach workers. Journaling is a technique of self-mentoring that can capture fleeting perceptions and insights. Journaling can also serve as a documentation of your own development as an outreach worker.

Different people use different journaling techniques, depending on their needs and what works best for them. In general, journaling involves keeping daily, weekly, or occasional notes on ideas, incidents, observations, and your own feelings about things that happen during your work as an outreach worker. Journaling is a way to form a ritual around periods of self-reflection about your work, and a way to help you step back and make sense of what you're seeing, doing, and experiencing. Journaling can also be a form of self-therapy, helping you get through some of the most difficult parts of the outreach process.

2.6 Realistic Expectations

Learning Objectives

1. Discuss the program-wide evolution of realistic expectations for the success of Project SAFE clients, and compare those expectations with your own experience.
2. Identify your own expectations of your clients, and discuss how those expectations have changed during your time as an outreach worker.
3. Discuss some specific realistic expectations that outreach workers have defined.
4. Discuss the difference between *expectations* and *hope*, the effects of these two concepts on your work, and ways of keeping hope alive while expectations change.

Expectations in Project SAFE

When Project SAFE began, the staff's expectations and definitions of client success were very high. Child abuse and neglect would be eliminated. Clients would learn to function well in their roles as parents. The families would stay together or be reunited. Clients would stop abusing alcohol and other drugs. The physical and emotional health of clients and their children would be improved.

Since then the realities of clients' lives—life-long histories of pain and hopelessness, the presence of multiple disorders, the lack of even basic life skills—have moved those expectations to the position of long-term goals. We now understand that recovery for these women is a long-term developmental process. It has to wash over them in waves, each time sinking in a little more and carrying them a little farther. Getting clean and becoming a responsible parent might take many episodes of treatment and recovery. But the first time through treatment is just as important to that process as the last.

In 1994, a group of Project SAFE and DCFS staff members came up with a new goal statement: "Our goal (related to substance abuse) is to enhance each woman's long-term capacity for recovery by helping her grow as much as she can at this point in time." This goal included starting her off on sobriety, replacing neglectful and abusing behaviors with healthy ones, and planting the seeds for long-term recovery and effective parenting. "Even if she relapses, she's farther along toward establishing long-term recovery than she was before she got here. Her capacity for eventual recovery and the family capacity for healthy functioning has been enhanced." (SAFE 94, p. 41)

When they were asked what Project SAFE has been successful in accomplishing, these staff members said:

- "We provide a safe, substance-free environment in which each woman can reassess her life."
- "We provide a non-judgmental, hope-filled environment that encourages healthy change."

- “We break the cycle of dependency by cultivating both the spirit and the skills of independence.”
- “Project SAFE saves lives.”

How do the expectations, goals, and accomplishments described above compare with your experience in Project SAFE? (If you’re new to the project, compare them with what you’ve been told about project expectations.)

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Have staff members’ expectations of client success changed because of the system-wide rules limiting the amount of time clients can spend in intensive outpatient treatment to 75 hours? If so, how have they changed?

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Expectations of Your Clients

Think of a client who’s fairly new to you. Write her name and briefly describe her present circumstances:

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Describe your current expectations of this client’s behavior—how you expect her to act, what you expect her to say, etc.:

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Describe your expectations of whether or not this client will graduate and what she will accomplish by the time she leaves your program:

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Think for a minute about the expectations you've had for your clients during your time as an outreach worker. Name any expectations that have been disappointed more than once:

Have those expectations changed? If so, what are your expectations now?

Outreach Workers' Experience

Here are some thoughts provided by other outreach workers who have seen their own expectations change over the years:

- It's important to remember that each client is different. What works with one client may not work with the next. You need to approach each situation with an open mind and not pre-judge the client based on others clients, or on her referral paperwork.
- You can expect resistance from a client at first. If it's not there, you're probably getting hustled.
- You can't expect the truth from a client when lying has always been her main means of survival. You can't expect her to open up to you about her family if her culture has taught her not to do that.
- Most clients have never had much reliable structure in their lives, and many have never had jobs. They find it hard to wake up at a certain hour and prepare for group, get their children ready, do their housekeeping, and do basic self-care.
- It's important to have realistic expectations for the children too, and to communicate those expectations to their mothers. In most cases the children had no structure before and no consistent rules to follow. Now that their mothers are getting better, the children have new rules to follow. This can cause confusion and rebellion. The clients need to help their children understand the changes they're going through in the program, so they can work through those changes together.
- If the client has custody of her children, and the outreach worker comes to care about the children, that can raise the worker's expectations of the client. It can test the outreach worker's tolerance and anger-management skills if the client continues to use while she's responsible for her children's well-being.
- Outreach workers who are in recovery may be particularly vulnerable to unrealistic expectations based on their own success in recovery. If you find yourself pushing clients in one way or another, look at your expectations and the sources of those expectations.
- It's just as important to have realistic expectations of yourself. You aren't a super hero.

If you try to be one, you'll end up making even more mistakes and burning yourself out. Then you won't be able to help anyone.

- It's important to see and celebrate the small successes, rather than hold yourself or the client to impossible standards.
- Clients need to hear about it when they're doing well. They need to know you notice that they're coming in every day, having negative drops, and doing well in the program. Their own expectations of themselves might be unrealistic, so you need to call their attention to their own small successes.

Are there any of those statements that you've found not to be true in your work? If so, which ones and why?

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What thoughts of your own can you add to that list?

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Expectation and Hope

Many people in the helping professions struggle with this question: When I have to keep my expectations reasonable, how do I keep feeling—and conveying to my clients—a sense of hope?

First a quick, informal definition of each term. *Expectation* is what we think will happen. If you turn on the water, you *expect* water to come out. If you drive 65 miles an hour past a cop in a 35-mile-an-hour zone, you *expect* to get pulled over. Just because something is your expectation, that doesn't mean it's good or bad. It's just your best guess at what will happen.

Hope includes all the things you want to happen that are somewhere in the range of possibility. We hope they'll come up with a cure for AIDS tomorrow, but we don't hold out the hope that we'll wake up tomorrow and AIDS will never have happened. We might wish that, but we know enough not to hope for it.

Hope is the most important thing that Project SAFE has to offer. You are, as one outreach worker put it, "the voice of hope" in your clients' lives. As important as it is to have reasonable expectations for your clients' progress, it's just as important to have unreasonable hopes.

Hope is like faith. It's not based on logic or on our observations of what's reasonable to expect right now. It's based on things we can't see or completely understand. In your own life, in your clients' lives, and in the lives of people you love, you've probably seen positive changes that you can't explain logically. Those are the things that hope is based on.

We all feel more hopeful some days and less hopeful on other days. When you're feeling hopeful, what message does this give to your clients?

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When your clients pick up on this message, how do they tend to react?

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When you're not feeling hopeful, what message does this give to your clients?

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When your clients pick up on this message, how do they tend to react?

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Please describe your best hopes for your clients:

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What words do you use to tell your clients about those hopes, and what other words might you use?

How do you convey those hopes to your clients without using words, and what other ways might you try?

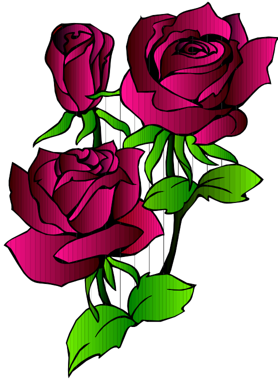
How are you going to keep your hopes high and alive while you keep your expectations realistic?

Who do you know who gives you a sense of hope, and how might you learn from what they do?

Don't Give Up

D. Banks MacKenzie of the Appleton Home in Boston, Massachusetts was quoted in the 1870-1875 Proceedings of the American Association for the Cure of Inebriates. He offered the following advice to people who work with addicts—words that are as valuable today as they were then:

". . . do not be hasty in giving up a victim as incurable. Your patience will be sadly tried, those you had the most confidence in will betray you, lie to you, deceive you and fall. Do not give up, forgive seventy times seven. So long as the prodigal comes back, acknowledges willingness to try again, the spark is there. This is a work of great trial but great rejoicing . . . the good seed is planted, and will bring forth fruit sometime."



Section 3.0
Outreach Worker Functions

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3.1 Client Engagement

Learning Objectives

1. Define "client engagement."
2. Describe the hope/pain synergism.
3. Describe five essential facets of the engagement process for addicted women.
4. Discuss why it's important to engage other important people in the client's life.

Definition

Engagement is the process of persuading a client to participate in treatment. She is engaged when she enters treatment and disengaged when she "drops out" against staff advice.

The Client's Perspective on Entering Treatment

After reading the following excerpts from outreach interviews, list the client's reasons for resisting treatment. Add to this list from your experiences or expectations.

> *Fear of change and just not knowing what to expect, and then they have low self-esteem and they don't think that they deserve these things anyway. So, in order for them to begin to trust, they have to see that "it's okay for me to accept this." Because in their lives they've always had to give something in order to get something. Nothing came easy. And recovery doesn't come easy. There's a price you have to pay for it.*
>
> *The bottom line is that DCFS has mandated them to do this, and any time you're mandated to do something, there's a level of resistance.*
>
> *I went to get her one day...They were sitting in the kitchen shooting up, you know? She...put her arms around me and she said, "This is too big for you. You're wasting your time. I want to do it. Look at that. I'm going to be this way for the rest of my life."*

From the client's perspective, what would be her reasons for resisting treatment?

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The Hope-Pain Synergism

You can measure the likelihood of successful engagement of a client by looking at the *hope/pain synergism* in her life—the ratio of hope (of the benefits of recovery) to pain (of the consequences of addiction). Where there is high pain and high hope—something that rarely happens in Project SAFE clients' lives—engagement can be quick and intense. Where there is low pain and low hope, there's very little chance that she will enter treatment.

It's in the combinations of high pain/low hope and high hope/low pain that the intervention technology of outreach is most important. In these cases, by letting persistence and consistent positive regard work their magic, outreach can change the equation and get the client engaged in treatment.

Early in their treatment experience, addicted women tend to have intensely conflicted feelings about treatment. Clients keep a foothold in both worlds—addiction and treatment—gingerly testing each step forward and backward. In this transition period we find strong patterns of thought and emotion that don't make sense or fit together. Examples of these kinds of contradictions include clients who want to keep using drugs **and** keep coming to treatment, and clients who want staff to go away because staff make them feel good and hopeful.

While some clients might express this kind of ambivalence in subtle ways, most often they play it out in dramatic behavior, like missing days in treatment, splitting in anger and then calling to get back in the Project, relapse behaviors, etc. True emotional engagement is rarely a bolt-of-lighting event. It's much more likely to be a slow process, with every stage marked by behaviors that may test you and the other staff members.

The Hope/Pain Matrix

High Pain HP	Low Hope LH	HP/LH is the most typical initial pattern encountered with SAFE women. External control and hope-engendering relationships are the key ingredients in treatment engagement
High Hope HH	Low Pain LP	HH/LP represents the honeymoon phase in the drug relationship. The drug relationship is experienced as a solution rather than problem. Poor treatment success; high risk of relapse.
HP/HH produces high internal motivation and rapid engagement in treatment. Good treatment prognosis.	LH/LP represents the post-honeymoon phase of the drug relationship. Trust building by outreach workers can set the stage for treatment engagement during future crises.	

Dimensions of Engagement

Experience in Project SAFE in Illinois has allowed outreach workers to identify and describe a number of critical dimensions of engagement.

Expecting Resistance

Resistance is to be expected; we should be shocked when it's not there and suspicious that we're getting hustled. These women initially see us as an extension of the Agency that's taking their children and forcing them to get help they don't need or want. It takes time to work through their anger and distrust.

In the beginning, they're very resistant. They don't trust. They see us in the beginning as the enemy, like we're working hand-in-hand with the child welfare agency and the only goal is to take their children. So they are resistant, they're angry, they're full of a lot of anger. A lot of moms are resistant about child care because they think we're going to take their babies to the child care and the child welfare agency will pick them up from the child care place.

Respect

On the initial visits: I try to remember that I'm on her turf—that I'm her guest and that I remain there only with her permission. I want to minimize my power and let her feel we're on the same level.

I try to empathize with her sense of being invaded—her feeling that all these strangers are getting in her business.

Ability to Listen

They can't hear you until you've heard them. The trick is to shut up and listen until they're ready to hear what you have to offer.

I think it's the first time they've been listened to and not judged.

So you have to show them that you care. And loving and listening. If it takes dropping a client off and sitting outside her house for half an hour and letting her dump a lot of stuff on you, that's what you have to do...Just listen; let them talk.

Self-disclosure

I wait for the right time and then I share my story and my gratitude about what happened to me as a result of treatment.

Identification *I listen to her story, and then I tell her mine. When she figures out I been where she's at, something just seems to click. It's like they want something I got and for the first time figured out it might be possible to get it.*

We're from the neighborhoods. We've lived in ...public housing sites. You go to the same stores that they do. You already know what they're going through. It's not like they have to hide anything. You may have been standing right there watching them when they got arrested. Or watching them...down at the bottom of the barrel so to speak. And they already know that you know this about them.

Empowerment *Its harder for the women I see in the projects because they don't see a lot of people making it. I hope she can identify with me in a way that opens up her sense of possibilities and choices.*

Affirmation *I tell her something good about herself—something I see that others may have missed.*

I just keep listening and telling her everything's possible until she asks me "how?" Then I tell her that her beauty's being wasted and what she can do for herself and her family.

I just keep leaving those "You can do it!" notes on her door.

I affirm her hope of getting her kids back. I tell her I think she's strong enough to do what it takes to get them back.

"I believe in you."

Lack of Judgmentalism *You can't be judgmental. You have to be willing to allow the clients to make mistakes and to be resistant, because that's what they are.*

When you do outreaching, one thing you need to do is be an equal. You have to let the client know that you're no better, that you're her equal.

Refusal to be pushed away *You've got to let them get all their anger out before they can hear anything you've got to say. When they're done cussing, I start talking.*

[I say through a closed door:] *I know you're there. I know you're mad. But I ain't gonna give up on you. I'll be back tomorrow. I hope you have a good day.*

At first she didn't want to talk to me, but I just kept showing up at all her court hearings.

Tenacity — [I break through the resistance by] *not giving up. Keep knocking on their door. Keep calling; say "I'm just calling to see how you're doing." They get to the point where they want to get you off their back. They just surrender. They finally realize that we're not going to let off. That we'll keep at it until we give them the help they desperately need.*

They have to know you care enough that you won't give up.

"She's not here? Tell her I will be back many times."

Reducing Fear — *I told her it wasn't scary—that it was like a club of women like her, that she would know people there.*

I'm like their personal coach. I describe what it will be like and tell them I will be there with them every day.

Aggressive Problem Solving — *My job every day is to resolve anything that threatens to keep this woman from getting to Project SAFE.*

I tell her this program is designed for her—that we have things other programs never had: transportation, day care, people who know how to counsel women.

Reality Therapy — *Who am I? I'm somebody who can show you how to get those people off your ass!*

I'm like a parent. In the beginning I tend to be really stern. Once the client is engaged, I can relax a little and work with that. When they backslide I may have to be a little more stern.

Individual Differences

Obviously, not every engagement dimension will be useful with every client. As other outreach workers have reminded us, it's important to remember that each client is different. You can't expect that a technique that worked with one woman will necessarily work with another woman. It's important to approach each new case with an open mind and seek out what motivates that particular woman. As part of this process, the outreach worker needs to assess how the woman is feeling about everything going on in her life at that point in the intervention.

Some sites have offered tangible rewards to motivate clients. For example, one site gave a woman a sitting for a portrait of her and her family when she completed treatment. Other sites have used personalized attendance logs or highly visible attendance charts, on which clients get stars for attendance. When they get enough stars, they can redeem them for various gifts. Still another site has given women welcome kits that include a number of toiletries and other personal

items.

What might be some other tangible and intangible ways to motivate individual clients?

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Engaging the Whole Family

Enabling and sabotage by family members, paramours, and other drug-using peers is a significant obstacle for drug-addicted women. When Project SAFE began, many outreach programs concentrated on the client and the children. But now outreach workers are saying that their focus has grown wider. The influence of ASAM criteria has increased their emphasis on working with more family members in order to build a stronger support system. The general experience in treatment used to be that many women would leave without a support system to return to; this was endangering all the gains made in treatment.

Engaging the children seems to be an easy and enjoyable task for outreach workers. Many transport children daily. This provides an opportunity for interaction and building a relationship. Many children look forward to the child-care experience; they tend to see the outreach worker in a positive light because she provides transportation to child care. One worker noted that the children get so excited about what they're planning to do in child care that they make their mothers get up in the morning and go to treatment so they won't miss the child-care experience.

Engaging other members of the family may be more difficult. Some outreach workers have reported that they don't work much with other family members; their agencies discourage family involvement in order to maintain confidentiality.

After some thought, write down what you believe the role of an outreach worker should be in engaging children, paramours, and other family members along with addicted women.

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3.2 Problem Solving Around Obstacles to Recovery

Learning Objectives

1. Name two major obstacles to recovery.
2. Identify ways in which outreach workers can help clients overcome each type of obstacle.

The Obstacles

Of all the obstacles to women's ability to enter and complete treatment, the most frequently mentioned is the lack of safe, accessible, and affordable child care. Lack of safe and drug-free housing is also a significant barrier for many women. Many fear the loss of their housing if they enter residential treatment settings. Throughout the history of traditional treatment programs, many women who were motivated to succeed would fail because of one or both of these obstacles. A major part of the Project SAFE outreach role is the task of helping clients overcome these obstacles.

Child Care

One client talked about all the work her outreach worker did in helping her solve child-care problems:

> *She worked very hard, you know, trying to get things worked from there for my twins. See I have a set of twins, so I have to take them to day care. So she worked very hard to get that done, cause since I was going to be coming here to the SAFE program. So she was very helpful with that, and I did my part too. You know, I had my part that I had to do, but, she was very—you know—outgoing and stuff.*

The following are examples of how outreach workers help women find and maintain child care. Add to the list from your own experience:

1. Regularly transport children to the child-care provider.
2. Locate appropriate child care if it's not provided by the agency.
3. Negotiate with the child-care worker whenever issues arise between the mother and the provider, or if there's any question about the appropriateness of care.
4. ____
5. ____
6. ____

One outreach worker said that she has a whole list of different day-care agencies in her community and the hours they're open—including agencies that are open 24 hours a day. She's checked out whether or not they'll take children by the hour while their mothers are in outpatient

treatment. Her most difficult challenge has been finding day-care slots in evening programs.

Housing

When we asked Project SAFE staff about housing, we quickly found out what a serious obstacle the lack of housing could be. The staff members had much more to say about the problem than about possible solutions. Here are some quotes from case managers:

> *It's hard for them to get housing. I mean, your chance of getting a job, getting hired on the job, when you're saying "I can't come this day, this day, this day because I'm in treatment." Once you tell the employer that, he's getting rid of you—or he's not going to hire you. So you don't have the money to get a place of your own. You don't have income if you don't have your kids. I've always said—and I believe—that's a setup for them to fail. To take their kids and tell them, "before you get them back, you need to get housing. You gotta complete treatment." "Well, I can't complete treatment and work, so I'm not going to get a place, which means we're running in this triangle here where I'm never going to get my kids back, because you set me up to fail." Yeah, they got the program that'll help them get a place, but it's only for so much money. Unless they're getting public housing, the money that they're going to give them to support them to get a place is not enough, because you got people with 2 and 3 kids, and you're asking them to pay $350-500 a month plus utilities. They can't do it. Not even on public aid, they can't do it. So you've set them up to fail. Nine out of ten times, they got kicked out of public housing because of the drug use, they weren't paying rent, or they let the drug dealers use their apartment—they got busted for drugs. They can't get back in there. . . I wish we could get the money to build our own halfway house.*

> *I had one instance where the housing coordinator wanted me to assure her—because they were trying to make these places drug free—that if she put that client there she would not use. She wanted me to verify that she would not use. I said that I can't do that,* [although] *that's our hopes.*

> [Housing has] *been a struggle because I've seen women who were living in conditions that were very inhumane. Having some knowledge about what DCFS offers, and the difficulties with the clients' not having adequate history—any credit background—they can't really find decent housing. The money is available, but how do you get linked with the service that will allow you to be able to afford the rent? You can't pay, even though they're willing to give you the normal funds to pay part of it. I have a client right now who belongs to that particular group. And what I've done to try to help her is to give her some resources as far as numbers to call and try to investigate the possibilities. They get discouraged very easily, so I try to encourage them. How important is this? She has three children, girls, and she really wants her children to have a nice place to live. When you get discouraged, I say, "just look at your babies."*

> *For the homeless, it's good to know places you can refer them and recommend. A lot of our women who have graduated through Project SAFE come out of Cabrini-Green; and you figure, they have a program, and now they're in recovery, and they have to return to Cabrini-Green. There's really no other way they can get out of there for the money that they're paying. It would be great if we could send them somewhere; that would help*

their recovery a lot.

If they are in the projects and they don't have a lot of income, we tell them that maybe they can get an apartment. We encourage shelters until they can get on their feet.

What solutions have you found to housing problems in your community?

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3.3 Home Visits

Learning Objectives:

1. Describe the purpose of home visits during the engagement and treatment phases.
2. Describe a number of things an outreach worker might do during a home visit.

The Purpose of Home Visits

The engagement process usually begins with a home visit, because this is often the outreach worker's first opportunity for contact with the client. Many outreach workers find that, on their first visit to a client, she isn't home or it's hard to get her to open the door. When clients are in treatment, most receive at least two home visits from their outreach workers.

In the words of one outreach worker:

> *The purpose of the home visit is to assess the client, the client's home life, the way they interact with their children, whether they have homemaking skills.*

What Goes On in a Home Visit—or—"You can't be a wimpy outreach worker!"

Here is how an outreach worker described the first home visit to a particular client:

> *You get a referral from a DCFS worker and you get a client appointment. You write a letter and go the client's house. The first time, the client is usually not there—usually* ***always*** *not there. So you leave a letter and then you go out the second time and see the client. You talk to the client and explain that "I'm* [name] *and I'm an outreach worker for* [agency]. *A DCFS worker gave me a referral. She or he wants you to have an alcohol and drug assessment."*
>
> *And they say, "What does that mean?" "It just means that you come in and you're going to be asked some questions, and possibly you might have to take a drop, but I'm not sure. I'm not going to say that you are going to have to when you're not going to have to." But these are some of the things. . .and they ask, "Is it inpatient?" "No, it's outpatient." "Well, how am I going to get there?" Then I say, "Slow down and let me explain it to you first, and then if you have questions, you can ask."*
>
> *I tell them it's an outpatient program. "It's five weeks, Monday through Friday. You get picked up, dropped off; you get child care." Then you can see they go from mad to laid-back, and they start to listen more.*
>
> *I say "We pick you and the kids up and drop you all off, and if there's anything that we can do to make you being in treatment easier for you, that's what we're here for." "Well, where do I go?" "Here's a letter, and this is the time of your appointment. I'm going to pick you up at this time so that you can be sure to be there for the appointment."*
>
> *Then I tell them they have to take the kids to the doctor in order for them to get the child*

care. "Well, how will I get to the doctor?" And I tell them I'll call their DCFS worker and maybe the worker can bring them some tokens so that they can make the meetings, take the kids to the doctor. "Other things that maybe we can't help you do, we draw in your DCFS worker and they help you."

So, they come here for the intake and they'll still be kind of leery, but once they start, they open up more. You have to rehearse it—you have to stay focused and take a lot of the bad things that they're going to say, a lot of punches. But you have to remain calm and at the same pace, because if you don't, that's it. You've lost them. If you don't hold their attention and do what you have to do to grab them and bring them in, you've lost them. You can't be a wimpy outreach worker: there's no such thing as that.

A client talked about a home visit this way:

One time she came to my house and I was going through, like, a grieving process, and she ... convinced me to come into the center to talk to my counselor, something that I didn't want to do.

The following are descriptions of actual home visits:

The following is an example of a home visit I went on today. I parked around the corner so she wouldn't see the van. I walked to the house and rang the bell and she immediately came down and she brought me upstairs. I think she's living with her boyfriend. I'm observing the house. I suspected she was high. She had her daughter over for visitation. The daughter was so dirty, you know. I'm scanning this place—for a safety factor, because I'd never met this guy. I don't really know what's going on. So I ask her about her lack of attendance. It's really amazing. A lot of them will look you right in the face. Her eyes were really glassy. I could tell she was bombed. It lasted for about 15 minutes.

I have a list of questions that I go through. [If] *they used during the week. . .If the bathrooms are clean, then—if the house is clean. Then I also see if there are burns on the furniture—which is my own observation—if the kids are dressed in clothes that they've slept in, or if they have clean clothes on everyday, if their faces are washed, if their dental needs are met.*

Yesterday, I did a home visit and it lasted an hour and a half. We went through family albums because I happened to know one of her uncles used to date one of my cousins. She got out the whole big book and showed it all to me. Just sitting there doing things like that, she said, "I never have had company before without getting high until I started coming to Project Safe. This is fun."

The above examples illustrate only a few of the tasks outreach workers do during home visits. Outreach workers also said they provide suggestions about keeping house and grocery shopping, and they talk with the children to supplement what the parent has said about what is going on in the household. Are there any other things you've done on a home visit, or heard others talk about, that aren't mentioned in the examples above? If so, please write them below:

____

____

____

____

Practice

It's your **first home visit** with a woman. List the topics that need to covered during the visit and observations you want to make.

1.____

2.____

3.____

4.____

5.____

6.____

7.____

Now, using your list as a guide, role-play your first home visit with the help of another person (preferably an outreach worker or other Project SAFE staff member). When you've finished the role-play, ask the other person for feedback on your performance.

Now make a list of topics you want to cover, and observations you want to make, on a home visit to **a woman who is already active in treatment.**

1.____

2.____

3.____

4.____

5.____

6.____

Using your second list as a guide, role-play this type of home visit with another person, then ask for feedback on your performance.

What would you do if...?

1. You get to a client's house, her small children are in the house by themselves, and she's nowhere around.

   ____

   ____

2. There's no place to sit in the house that looks clean or uncluttered, and out of the corner of your eye you see things crawling around.

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3. The client has been getting more independent, you've sensed that her paramour has started feeling threatened by this, and when you go for a visit you see that she has two black eyes.

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4. You go to visit a woman and she slams the door in your face.

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5. You get to the house and see that there are people in the other room shooting up.

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3.4 Monitoring Abuse and Neglect Issues

Learning Objectives

1. Define "child abuse" and list the types of acts considered by law to fall in that category.
2. Define "child neglect" and list the types of acts considered by law to fall in that category.
3. Describe three ways you might monitor abuse/neglect in your outreach role.
4. List the procedures prescribed by your agency for responding when you suspect abuse or neglect.
5. Using the definitions of abuse and neglect, evaluate examples seen by outreach workers.

Definitions

The Illinois Abused and Neglected Child Reporting Act (P.A. 81-1077, effective July 1, 1980, as amended, defines an "abused child" as:

- a child whose parent or immediate family member, or any person responsible for the child's welfare, or any individual residing in the same home as the child, or a paramour of the child's parent:
    a. inflicts, causes to be inflicted, or allows to be inflicted upon such child physical injury, by other than accidental means, which causes death, disfigurement, impairment of physical or emotional health, or loss or impairment of any bodily function;
    b. creates a substantial risk of physical injury to such child by other than accidental means which would be likely to cause death, disfigurement, impairment of physical or emotional health, or loss or impairment of any bodily function;
    c. commits or allows to be committed any sex offense against such child, as such sex offenses are defined in the Criminal Code of 1961, as amended, and extending those definitions of sex offenses to include children under 18 years of age;
    d. commits or allows to be committed an act or acts of torture on such child; or
    e. Inflicts excessive corporal punishment.

According to the same law, a "neglected child" is:

- any child whose parent, or other person responsible for the child for the child's welfare:
    a. withholds or denies nourishment or medically indicated treatment, including food or care, denied solely on the basis of present or anticipated mental or physical impairment, as determined by a physician acting alone or in consultation with other physicians;
    b. does not provide the proper or necessary support, or medical or other remedial

care recognized under state law as necessary for a child's well-being, including adequate food, clothing and shelter;

c. who is abandoned by his or her parents or other person responsible for the child's welfare; or

d. who is a newborn infant whose blood or urine contains any amount of controlled substance as defined in the Illinois Controlled Substances Act or a metabolite thereof, with the exception of a controlled substance or metabolite thereof whose presence in the newborn infant is the result of medical treatment administered to the mother or the newborn infant.

Monitoring Abuse and Neglect

The following are examples from the interviews with outreach workers of how they monitor abuse and neglect. Add to the list from your own experience:

1. Observe the home environment for cleanliness.
2. Monitor the behavior of the women toward their children in the van/car.
3. Look for outward signs such as scratches, bodily marks, a man lying around the house.
4. Listen and look for issues with food in the home or in the van. Signs of these issues might include the absence of food in the home, extreme hunger on the part of a child, a client's withholding food from her child as punishment, etc.
5. Assess whether children are dressed properly for the weather, or whether their clothes might be intended to hide bruises or scars. As one outreach worker said, "If it's a warmer day and she's got a turtleneck with long sleeves, something's not right."
6. Assess whether or not there are signs that the woman might still be using. For example, is she clean, or is she still wearing the same clothes she wore to group the day before?
7. See if the children are clean. Are they dressed in clothes that they've slept in, or do they have clean clothes everyday?
8. ____
9. ____
10 ____
11. ____

What procedures do you follow in your agency if you suspect child abuse or neglect? For example, would you make the report to DCFS? Would you always discuss the situation with your supervisor before you made the report?

____

____

____

The following are examples from actual home visits. After reading each, decide whether or not you believe it's an example of abuse or neglect. If you believe it is, write whether you believe it's abuse or neglect, and provide the letter(s) describing the type of abuse or neglect from the statutory definitions listed above. Also, tell what you think should be done in that situation.

I made one home visit where these kids had bruises from the bottom of their feet to the top of their heads. Everywhere. One of the kids asked me if I wanted something to eat. And I said "No, thank you." And he said he was hungry and he went to the kitchen, in the refrigerator, and got a can of dog food and started eating it. And the lady was so embarrassed she grabbed the can and whooped the boy.

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____

One lady, her house was real clean. She had a mousetrap about this big, and the little kid was playing with it. That little boy could have broke his hand when that trap popped. It was a big trap, a huge trap. It was a little kid, about one year old.

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____

I went to do the home visit. It was in the neighborhood. I went to the house. The children were in the house and I could see that it was a basement apartment. I kept asking, "Where's your mother?" Finally, the little boy who I think was two years old answered the door. I walked in the apartment and the mother was knocked out. She looked like she had been using for days.

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We had an incident yesterday where, I guess, the living conditions weren't very good. The roof fell in.

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____

The home was so bad. There were feces on the floor. . . from the dogs and the baby diapers.

____

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Reading Resources

Child Abuse and Neglect Statistics: Annual Report—Fiscal Year 1994. (1995). Springfield, IL: Illinois Department of Children and Family Services.

3.5 Providing Transportation

Learning Objectives

1. Explain the importance that transportation plays in the treatment of addicted women.
2. Describe the types of trips that are acceptable for your agency.
3. Describe three ways that the outreach worker can support clients' treatment while providing transportation.
4. Suggest a set of rules that would be appropriate for use in the agency van or car.

Role of Transportation

DCFS offices and local treatment agencies often cover large geographical areas. This makes it difficult for most women to get to treatment. In urban areas, safety issues often make the use of public transportation difficult or inadvisable. Some women also have to get children to child-care providers in order to attend treatment. For these and other reasons, the lack of transportation is a major obstacle that many women need help to overcome before they can participate in substance abuse treatment.

Strategies for helping women overcome this obstacle have included providing bus passes to clients to get to treatment, organizing client car-pools, and tapping the resources of local health and human service transportation services.

More often, outreach workers provide the needed transportation to and from the treatment agency, self-help meetings, and other destinations. They do this in agency vehicles (sometimes in vans), or in their own cars.

Clients often talk about the transportation aspect when they describe their outreach workers. For example:

> *She . . . is more involved with us, you know, as far as, you know, taking us around to do our business, picking us up, bringing us to group . . .*
>
> *She took me to the stores and things that I had to do, like carrying me, going with me to cash my check and different things . . . she was always very patient with me, like if I had to go to a whole lot of different stores, she was willing and she never, you know, like rushed me, or "hurry up," you know.*

Destinations

Different agencies have different policies and practices regarding transportation. Check any of the following destinations you typically take clients or their children to:

__ Outpatient treatment

__ Social Security Office
__ Medical office (for the women)
__ Medical office (for the children)
__ Job interviews
__ Grocery stores
__ Child care centers
__ Schools or training sessions
__ Self-help groups
__ To buy clothes (for the women)
__ To buy clothes (for the children)
__ Assessment interviews
__ Other______________________________
__ Other______________________________
__ Other______________________________
__ Other______________________________

What else happens (besides getting there) during transportation?

When we interviewed outreach workers about transportation, we found out that clients often viewed the van as a “safe place” where they felt comfortable and often revealed things that they didn’t talk about in traditional treatment settings. Outreach workers reported that they sometimes suggested going for a ride in the van to talk things over, if the client’s home didn’t offer privacy or safety. Another worker described a woman who was totally different (more cooperative) when she was in the van than when she was in her home or around other people. How can outreach workers help while they’re providing transportation? Below are examples of how some outreach workers have tried to make van or car rides an extension of the engagement and treatment experience:

Encouragement

If they finally hook into the outreach worker when she shows up on their door (a lot of times for the 10th or 20th time), then we'll get them and they'll stay with us. A lot of that is the encouragement on the van. You know, "Just go. It'll be O.K." When they come out angry [from treatment, I say] . . . "Just think about that. You know you're coming back tomorrow." I mean, it's that constant encouragement.

Helping the conversation stay positive

After clients have been in treatment, been to groups all day, and I'm taking them home, they usually would like to talk amongst themselves. If a client saw a building and said, "I used to buy drugs there," I would immediately tell them to bring that to the present. I would shift it to something positive, because I know that if you're trying to make a change and someone is constantly talking to you about the past, you are going to be stuck in between. I tried to talk to them about what they learned in group.

Staying aware of what's going on

[It's important to] *be aware of the attitudes of the women in the van. We had one client that got pissed off at another client, and the client was going to tell her on her own—confront her—and I said, "No, take it to group." And she did take it to group, which was the right way to do it. But you know, they can get pissed off at each other.*

Being part of the treatment team

We're in the [all] *staff meeting saying things that they have said to us . . . and their counselor is sitting there with her mouth wide open . . . "When did you hear this? That's not what she said in group. Well...she touched on it a little bit in group..." But she let it all hang out in the van . . . They want to talk to the outreach worker . . . They pretty much feel like we're on their level.*

Helping to de-stress parenting

[To make things go more smoothly in the car] *I play with the children. Once you get their attention, it seems like the mother calms down. Then the moms don't feel like they don't have the whole responsibility.*

Rules

In their interviews, all of the outreach workers reported that rules are necessary for the safety of the women and children who use transportation. Some workers reported having a list of rules taped in a conspicuous place in the van or car, or asking women to sign the list before they could ride. Other workers described some unwritten rules. One outreach worker, who kept a copy of the rules taped to the back of the bench seats in the van, described her rules this way:

We have 12 ground rules. First, no profanity, period. No hollering out of the van. They'll see a guy on the corner and want to holler out of the van. None of that. No beating on the window at people. No talking about clients when they're not in the van. Keep the focus on themselves. We don't allow them to criticize other people. If a person misses a day, its very upsetting to know that the others were talking about them. Cleaning up after themselves. Being responsible to buckle themselves in. And also, to keep an eye on the children. It's their responsibility to buckle those children up. Calling me on my pager when they're not going to show up. I don't want to go way across town to someone's house if they're not coming. It's their responsibility to call me ahead of time. No eating in the van, but I sometimes relax that a little bit, because I know sometimes they rush out of the house with a sandwich . . . but I try to get them to clean up after themselves.

Below are a number of areas in which outreach workers have found it important to have rules for the transportation process. For each of these areas, decide whether or not you think there should be a rule. If you think there should be a rule, write a rule that would be appropriate and useful to you; if you don't think there should be a rule, explain why:

1. Smoking____

   ____

2. Seat belts____

   ____

3. Car seats ____

   ____

4. How long the driver will wait____

   ____

5. Van/car capacity____

   ____

6. Transporting nieces and nephews (when clients are babysitting)_____________________

   ____

7. Who sits up front____

   ____

8. Stopping for errands on the way (for example, to buy cigarettes)___________________

   ____

9. Eating____

   ____

10. Other____

   ____

11. Other____

   ____

What would you do if . . . ?

The following are examples of situations that might occur in the van or car. How would you handle them?

You're in heavy traffic. You look up and two clients are arguing with one another in the back of the van.

____

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It's time to drive clients home after IOP, and it's in the middle of a terrible snow-and-ice storm. You've never driven a big van in that kind of weather before, and you're scared.

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You're scheduled to pick up a particular woman, but the last two times you went to pick her up, she wasn't home.

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You drive up to the shelter where a client lives and honk your horn to signal for her to come out. Another woman comes out and asks you not to honk your horn in the future, but to come up to the door to ask for the woman.

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A child gets in the car in the afternoon and talks about being very hungry. After you talk with him for a while, it becomes clear that he hasn't eaten anything all day.

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3.6 Linkage to Support Groups

Learning Objectives

1. Discuss the importance of clients' involvement in a culture of support and recovery, and the types of support groups available.
2. Identify five types of obstacles to successful involvement in supportive cultures.
3. Discuss ways of identifying these types of obstacles in women's lives, and ways of overcoming them.
4. Discuss the benefits and challenges to outreach workers and clients when the outreach workers who are helping clients get involved in recovery activities are also in recovery.

Cultures of Support and Recovery

If the "high" of the drug were your only rival for your client's loyalty, your task would be much easier. But as you know, you have many rivals. There's the ever-seductive culture of using, full of people and places whose importance has grown large as the need to use has increased. There's the comfort of knowing that all her difficult choices are being made by the drug, the strange comfort of hopelessness and helplessness. And there's the face of death, somewhere in the background, the final option of relief from all that pain.

Putting aside the ways in which addiction has harmed your clients, how has the *culture* of addiction helped them survive emotionally, and possibly in other ways?

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How does a client feel when someone asks her to give up that culture? What are her major fears?

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In most cases the client's involvement in the culture of addiction has been developing for years. Seventy-five hours in treatment is not going to stop it or replace it. So one major task of outreach is to ease the client into a culture of support and recovery that will replace the culture of addiction in her life. This new culture must provide all the benefits that the old culture provided, but in new ways: pleasure that's not related to drugs or alcohol, friends and companions who live clean and responsible lives, hope for continued growth and development, awareness of a range of choices and the courage to make them, and a sense of loyalty to life and health.

The number of available self-help options varies from community to community, but here's a general list:

- Twelve-Step sobriety groups like Narcotics Anonymous, Cocaine Anonymous, and Alcoholics Anonymous
- Women for Sobriety/Women for Recovery
- Churches and church-based support groups
- Non-spiritual sobriety groups such as Rational Recovery, and Secular Organization for Sobriety
- Other Twelve-Step recovery groups like Al-Anon, Adult Children of Alcoholics, and Incest Survivors Anonymous
- Support groups for victims of domestic violence and sexual assault, grieving groups, etc.

Overcoming Obstacles to Involvement

For many women who come from painful life circumstances and severe addictive patterns, successful involvement in the recovery culture seems impossible. They face obstacles that most people never have to face. But Project SAFE outreach workers can often break down the many obstacles to involvement and address them one by one. Women who had never had success with self-help groups before are finding ways of attending meetings, staying clean, and forming life-sustaining recovery relationships.

It helps to separate the obstacles according to type, because the different types require different solutions. We'll look at five types of obstacles here: Resistance to Change, Logistical Obstacles, Philosophical Differences, Cultural Differences, and Emotional Safety Issues. Sometimes these types of obstacles will be revealed in layers: For example, after you help a client overcome her resistance to change and solve her logistical obstacles, the philosophical, cultural, or emotional safety issues will often come up.

1. **Resistance to Change:** Sometimes resistance to change, pure and simple, is enough to keep a client from trying meetings or other gatherings, or to keep her from building any momentum in her meeting attendance.

   What might be some signs that a client is experiencing resistance to change?

   ____

   ____

   ____

   What kinds of questions would you ask to find out if resistance to change is an obstacle for your client?

   ____

   ____

At many Project Safe sites, outreach workers help clients overcome their resistance to change by having recovery group speakers talk at orientation sessions, taking clients to their first few recovery meetings, introducing them to women with a history of clean time, using incentive systems (like a star on the calendar for each meeting attended), and requiring that clients get the meeting chair's signature on attendance sheets. What other ways can you think of to help clients overcome resistance to change?

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2. **Logistical Obstacles:** Many clients don't know where the meetings are, don't have transportation to recovery meetings or church services, don't have money or tokens to use public transportation, and/or don't have child care at meeting times. For many clients, issues of physical safety form difficult logistical obstacles. Simply going outside their apartment at night puts their life at risk.

   What might be some signs that a client is experiencing logistical obstacles?

   ____

   ____

   ____

   What kinds of questions would you ask to find out if logistical obstacles are keeping your clients from attending self-help sessions?

   ____

   ____

   At most sites, outreach workers give clients schedules of recovery meetings, circling those that are within walking distance. Some outreach workers give clients bus tokens or help them apply for tokens from social service agencies. Some help clients think of ways of getting child care or rides to meetings. What other ways can you think of to help clients overcome logistical obstacles?

   ____

   ____

   ____

   ____

3. **Philosophical Differences:** The non-specific form of spirituality discussed in most Twelve-Step meetings works well for many clients. Others have received images of a judging, punishing God from religion; they need to have the difference between spirituality and religion defined more clearly. Some need a non-spiritual form of recovery. Others need a spiritual format in which the word "God" isn't used to describe the source of spiritual strength. Still others do need an explicitly religious format, where specific religious terms and instructions are used. Many women are most comfortable with, and most inspired by, the culture-specific religions with which they were raised.

What might be some signs that a client is experiencing obstacles because of philosophical differences?

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What kinds of questions would you ask to find out if philosophical differences present any obstacles for your client?

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____

Some Project SAFE staff address their clients' concerns about spirituality and religion by keeping those two concepts clearly separate. Others introduce their clients to non-spiritual alternatives to Twelve-Step programs, or to spiritual groups in which the word "God" isn't used. Clients who want an explicitly religious approach are encouraged to attend the churches of their choice, and some churches have formed recovery groups. What other ways can you think of to help clients overcome philosophical barriers to participation in self-help?

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4. **Cultural Differences:** Culture has much to do with the general atmosphere and way of doing things in recovery meetings, church services, and other self-help formats. For example, many meetings that are predominantly African-American are very different from those that are predominantly European-American. If a client's sense of belonging is fragile to begin with, going to a recovery meeting where people act and express themselves in a way that's very different from hers and her culture's can be anything from disappointing to destructive. Beyond that, if a client has been exposed to prejudice and discrimination and has had few positive relationships with people of the dominant culture, a meeting composed of those people isn't likely to feel emotionally safe for her.

What might be some signs that a client is experiencing obstacles because of cultural differences?

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What kinds of questions would you ask to find out if cultural differences present any obstacles for your client?

____
____

In many areas, particularly in urban areas, there are Twelve-Step meetings that are predominantly African-American or Latino. Project SAFE staff have learned where these meetings are and mark them in clients' schedule books. What other ways can you think of to help clients overcome cultural differences?

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5. **Emotional Safety Issues:** For many clients, recovery meetings and church services don't feel emotionally safe. They have overwhelming fears and feelings of being judged and being different from—and inferior to—others. For many women, meetings that also include men can feel unsafe because it's hard for them to speak honestly about personal issues in the presence of men. For women who have a hard time resisting involvement with men or saying "no" to persistent or predatory men, co-ed meetings might be sources of danger. The often high levels of intimate sharing at these meetings can set the stage for sexual and/or emotional involvement—involvement that puts recovery at high risk.

   Aside from sexual issues, other areas of danger also exist. For example, in some individual Alcoholics Anonymous meetings, clients might meet members who use shaming techniques to try to motivate newcomers (like telling people with depression that they're "on the pity pot") and interpret the AA literature in ways that discount the clients' experience. Even clients who are in tune with the general Alcoholics Anonymous philosophy and meeting format often find these specific meetings much more harmful than helpful. And finally, if clients believe that you're encouraging them to have ongoing involvement with self-help groups so that they won't need your help any more, this can trigger fears of abandonment.
   What might be some signs that issues of emotional safety are presenting obstacles for a client?

   ____
   ____
   ____

   What kinds of questions would you ask to find out if issues of emotional safety present any obstacles for your client?

   ____
   ____

   Going to the first few meetings with clients, introducing them to people who won't violate their emotional safety, and preparing them for meetings by bringing in recovery group speakers can help some clients deal with the fear of being judged and being different. Women with dual disorders will need therapy outside of recovery group meetings, and will need to take any required medication consistently, or they'll have a hard time learning to attend recovery group meetings and build support networks. To

side-step the gender issue, many outreach workers steer clients toward all-women's meetings. Some communities have meetings of African-American women. It's also a good idea to know what a specific meeting is like—and what the people who usually attend it are like—before referring clients to it.

Your clients' involvement with self-help groups should begin while you're still very much involved in their lives. These two forms of support must be carried on at the same time. If you get a sense that a client feels you're planning to abandon her, you can reassure her that you'll still be there for her even after she builds a full life in recovery. What other ways can you think of to help clients overcome emotional safety issues that are blocking their involvement in self-help groups?

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As the obstacles have been removed, many clients have found that they no longer feel "sentenced" to recovery activities. The people they meet, and the social networks they form, more than make up for the loss of their old using friends. The principles and rituals of their support systems—and the long, slow process of personal growth—serve to heal the pain that the drugs both masked and aggravated.

Considerations for Outreach Workers in Recovery

What are some of the benefits of having outreach workers who are also recovering from addiction introduce clients to self-help groups?

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What are some of the complications that might come up?

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How might these complications affect the client?

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How might these complications affect the outreach worker?

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If you're in recovery for addiction, you might sometimes wonder how much information about your personal history to give your clients. Different sites and supervisors have different guidelines on this, and different outreach workers are more or less comfortable talking about their experiences. If you're in recovery, and if you have guidelines that you've set or received from your supervisor or your agency, what are those guidelines?

Some of the outreach workers who were interviewed talked about the importance of setting clear boundaries between the client's and the outreach worker's recovery activities, to give each one privacy. This can be difficult if both live in the same neighborhood, go to the same meetings, and socialize with the same people. The outreach worker whose clients are present at her meetings may have a hard time separating her work and personal lives. And the client whose outreach worker shows up regularly at her meetings may have a hard time learning to relate to her as just another group member. What are your thoughts on appropriate boundaries for clients and outreach workers in recovery groups?

A number of clients expressed gratitude for the message of hope that outreach workers in recovery can bring. One client described that message as she heard it from her outreach worker's words and actions: "I been there, you know? I know how it is. I know the loneliness and the anger and the denial and everything like that. I know that. I been there, but it's a light at that end of the tunnel. You will see that light."

Resources

For an in-depth look into the addiction and recovery cultures, read White, W.L. (1990). *The Culture of Addiction, The Culture of Recovery.* Bloomington, IL: Lighthouse Institute.

3.7 Parenting Support

Learning Objectives

1. Define "parenting support" and give examples of this process.
2. Describe the outreach worker's role in providing parenting support to clients.
3. Name three different ways an outreach worker can provide parenting support.

Definition

In Project SAFE, "parenting support" has many facets. It includes:

- providing emotional support to the addicted woman in her mothering role;
- serving as a parental role model;
- providing in-home consultation to women in treatment who are taking parenting classes; and
- working to enhance the relationship between the mother and her children.

The intense stress of the mother's role makes this kind of support essential. Being a mother is especially difficult for women who have substance-abuse problems; who have no partners or other natural support systems; and who often have no foundation for, or experience of, effective parenting. Many of these women have had poor parental role models or have lost their parents through death or separation.

Background and Examples

Most agencies have parent-training programs for women in treatment. The outreach worker has a unique opportunity to help clients both understand and apply the knowledge and skills they learn through the parent-training curriculum. Project SAFE staff have found that these programs must include both personal living skills and basic caretaking skills. This may include training in housekeeping, cooking, grooming, dressing, and social communication skills—everything from how to pack a diaper bag and prepare bottles to the importance of immunizations and realistic expectations for child development.

The following are examples of different kinds of help:

Providing emotional support specific to parenting

You know. . . if it was a situation about my kids that had me kind of down, she would just talk to me, tell me to keep my head up, you know, things would work out. (Client quote)

Fostering the mother/child relationship

[While I was in treatment] *she made sure that the kids came, and made sure that my visits were increased—stuff like that.* (Client quote)

I can think of an incident where the mother had three children. The two older children were very active, but the youngest child was just blank. And [the outreach worker] *brought it to my attention and we met with the mother, and after talking with her we found out that she didn't bond with the child. She didn't want the child, so we were able to refer her to counseling. After about four months, her bonding began to take place and you could see a difference in baby and mother.*

Helping with routine parenting activities

I've had to go into their homes and help them get their children ready.

If we go into a house that's untidy, we give the mom suggestions as far as how to help the home get better. How to go grocery shopping. We help them make a grocery list. Tell them to clean up the house at night before the kids go to bed. Then in the morning, all you have to do is make up beds. So we don't put them down because their homes aren't clean. We give them suggestions on how to make it better.

Helping with medical issues

A lot of clients haven't taken the kids to the doctor, so we make the appointment. We call like we're the mom, make that appointment for them, tell them when it is and see if they can get there on their own, and if they can't, we take them. . .Once we start helping them, they find the means to do it on their own. But, initially a lot of the footwork as far as getting the child into school or to the doctor, we have to do it, because the client won't do it.

The outreach worker said something was wrong with the child. The mother said she took her to the clinic and got medication. The mother was administering the medication. We had her bring the medication, but the child didn't look any better after two days. We were able to take the child directly to the hospital with the mother. The child was dehydrated and losing fluids. So they said that had the mother not been encouraged to bring the child in, the child probably would not have made it. That was one instance, had the outreach worker not been there. . .

Providing guidance

[The outreach worker] *is like a surrogate Mom or extended family member. . .someone who can steer them in the right direction in terms of what to do with their children—things they are not familiar with.*

A lot of these people don't even know that you can go to the zoo free. Pack a lunch—peanut butter and jelly and a little snack here and go to the zoo and just have a ball. They don't know these things. A lot of them think that "everything I do with my kids is going to cost me money and all I get is this much money each month."

We give each other suggestions, and I think toward the end they finally see that this child was just like you—you weren't cooking for this child, you weren't feeding the child. The child had no rules they had to follow. Now all of a sudden you want to cook, clean up, give them rules. You have to let the child know what you're going through, the transition you're going through, so you can go through it together. . . there's no book that comes

with children. You have to let them know: "Mommy was doing some things that weren't good, and now I am trying to get help, and now you have to help me."

Teaching how to cope with the stress of parenting, or helping to reduce that stress

Well, we take them on trips. We have a couple of trips planned this month. To the zoo and a cookout with the moms and the kids. Just. . . trying to bring them together and help them to understand the feelings that they are going through when they get stressed, and how to deal with it instead of taking it out with their kids. [We tell the mothers,] *"The catch is that we're taking all of your kids. If you've got four kids, you're responsible for four kids. We're going to be there supervising, and if you get overwhelmed we'll step in. But we want you to remember what it's like for Joey to throw a tantrum, Suzy to get tired and can't walk and you have to carry her, Becky's pulling on Suzy's hair—all at the same time. We want you to remember that! So we are taking them all with us."*

We talk about frustration and anger and sometimes how we have to stop and count to ten or say a prayer, and then deal with the children—my son is three years old so I definitely can relate to what they're talking about.

A lot of the time they're embarrassed because they don't really know how to parent the children and they're going to naturally act out. And they want them to be on their perfect behavior and that's just not going to happen. So I personally try to connect with [the kids] *right away. Kids love that. And it seems to calm the parent down a lot.*

Providing material help

Like if the kids need things like—you notice one kid doesn't have on any socks. When we go shopping or go places, we pick up stuff and give it to them. If we go to Catholic Charities—we just gave one woman a whole big sack of baby clothes that we got from a friend's aunt. So we help them out in ways like that. We find toys to keep the kids busy so they can have a little peace.

I carry little extra snacks in the car, because a lot of the women don't feed their children in the morning.

Reinforcing lessons from parenting class

[The child] *got Waterford crystal glasses and—I don't know—he did something with them. It was a no-no. She said, "Before I started coming to parenting classes, I would've spanked him. He knows he doesn't do that!"*

She told me that she learned so much from the parenting classes. And I thought that was good, because she said that was the only way she knew to discipline. Do what I tell you to do. . .and after the third time, then I get my belt. And she says, now, "I'm learning other ways." And then we talked about different instances—she told me things she did, "time-out" and all that.

Describe examples from your own experience of how you've helped in the following areas, and add other categories of parenting support that you've provided:

1. Providing emotional support____

____

2. Fostering the mother/child relationship____
____

3. Helping with routine parenting activities______________________________________
____

4. Helping with medical issues____
____

5. Providing guidance____
____

6. Teaching how to cope or helping with the stress of parenting_____________________
____

7. Providing material help____
____

8. Reinforcing lessons from parenting classes_____________________________________
____

9. Other____
____

10. Other____
____

If you don't teach the parenting class at your agency, ask your supervisor if you can sit in on some of the classes or read through the curriculum. Ask the instructor what skills she'd like you to reinforce on home visits.

3.8 Crisis Management

Learning Objectives

1. Define “crisis.”
2. Examine typical crisis situations and talk about how they might be addressed.

Definition of “Crisis”

A crisis is a state of being caused by unexpected changes in the environment or the person that, if it’s not managed in a timely and appropriate way, can be harmful to the person in crisis or to others. An outreach worker’s job includes being available to the client and her children in times of crisis, to provide the support needed to manage the crisis, or to link her with other appropriate sources of support.

Examples of Crises

Examples of crises with this population are homelessness, acute health problems of the mother or child, or hints or threats of suicide. One outreach worker described the crisis-intervention role this way:

> *What do we got? About eight or nine ladies now? I can say everybody’s different. And where this fire may be little, this fire may be big, if you don’t catch this one right now, it’s going to be super big! It’s always something. There’s never a dull moment with our ladies. No, they keep you going.*

Handling Crises

As one outreach supervisor told us, it’s important for an outreach worker to be able to know what level of crisis he or she can handle. It’s equally important to know which crises must be handled immediately, and when it’s necessary to bring the client back to talk to a therapist. In the space below, write what you’ve learned about handling crises from your agency, and any questions you have about crises or methods of handling them.

___

___

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___

What would you do if. . .?

Several case managers talked about homelessness as the most serious crisis faced by the women with whom they work. The following are real-life examples of crisis situations faced by outreach workers. After reading each case, list the steps you'd take in dealing with the crisis.

> *One of the clients relapsed and I came over to pick her up. Her mother kicked her and her babies out onto the street. And they were just standing there with a suitcase, waiting on me. It was cold outside and she was crying one minute and okay the next.*

____

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> *There was a time where one of the females was very, very intoxicated and she had a violent history and we were quite aware of that—but she had been doing really well. And she went and stayed in her apartment and she wasn't coming in to her groups. So I thought, "Well, I better get over there and see what's going on," because she missed the group that day. Well, I wasn't able to get over there until later in the afternoon and, of course, she was very intoxicated and she was very upset with her significant other and she was going around taking knifes and forks and going around. . .and it's like. . .she's using very foul language and saying that I'm going to do this and do this to that.*

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> *A client is talking about suicide.*

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> *It becomes evident that the man she lives with is abusing her.*

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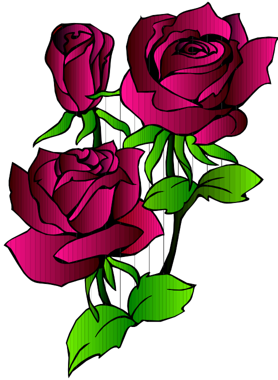

Section 4.0
Issues in Service Delivery

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4.1 Providing Outreach Services to Women of Color

Learning Objectives

1. Become more aware of your own cultural attitudes where women of color are concerned, and how those attitudes might affect your work with clients.
2. Discuss some of the issues that many African-American women and Latinas bring into treatment.
3. Discuss some of the strengths and other resources that are prevalent in African-American and Latino cultures, families, and communities.

Why Address These Needs Separately?

In most cases, a woman's life is affected profoundly by the culture into which she was born. Much of how she thinks and feels about herself, many of the circumstances that surround her, and many of the decisions that shape her life are influenced by the color of her skin, the language she speaks, the customs she learns, and the whole web of attitudes and prejudices that have been held up like a mirror all her life.

Many women who "fail" treatment do so because treatment programs fail to understand their cultural realities or to meet their cultural needs. That's not what it says on their charts, of course. They never told anybody this was why they dropped out of treatment. In many cases, women wouldn't know how to begin to explain the problem, even if they felt safe saying anything. In most cases, they've been taught to blame themselves instead.

More than most other treatment programs, Project SAFE has been designed with full knowledge of, and respect for, the specific needs and realities of women of color. Unfortunately, that's not enough. Every staff member needs a personal awareness and understanding of everything that a client's culture means to the client, and to the staff member. Every program must use culturally appropriate resources and language. And everyone who works with a client must be fully aware of the strengths and resources within her culture that can help her succeed in recovery.

Looking at Yourself

In working with women of another culture—or even of our own culture—the most important foundation is an honest appraisal of your own cultural attitudes and beliefs. As you answer the following questions, use the name of the culture to which the women with whom you work belong. If you work with both African-American and Latina women, do the exercise twice. Complete the following statements, writing whatever comes to mind (don't try to write just what you think people want you to write). Answer these questions even if you are of the same culture.

African-Americans/Latinos are:____

____

____

____

African-American women/Latinas are:____

____

____

____

Chemically dependent African-American women/Latinas are:_____________________________

____

____

____

How do you think your African-American/Latina clients see themselves?___________________

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____

How do you think those self-perceptions affect their success in treatment?__________________

____

____

____

When you were answering those questions, how did you feel?_____________________________

____

____

Our most powerful feelings, attitudes, and beliefs about our own culture and other cultures come from our life experiences. We need to be fully aware of those experiences and their impact on us. Then we can see where our feelings, attitudes, and beliefs might be getting in the way of our effectiveness in our work, and take steps to keep that from happening.

Please take a moment to think about what you learned about African/American and/or Latino cultures, women, and men in various areas of your life and development. You might have learned these things through what you saw, what you were told, what you experienced, etc. What did you learn about African-Americans/Latinos:

...in your family of origin?____

____

____

____

...in your experiences with those communities (in school, play, dating, etc.)?_________________

____

____

____

...in your professional life?____

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...from the environment (the media, etc.)?____

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The Effects of Cultural Attitudes on Clients

As you read in the module on "Realistic Expectations"—and as you've learned from your clients—much of the success of treatment rests on the client's ability to believe that there's hope for her. If the mirror that your attitudes hold up to your client shows a person with inner strength and beauty, she's more likely to find that strength and use it to defend her inner beauty. But if the mirror you hold is distorted by negative cultural images, she'll see those images. At best, they'll damage her ability to trust you. At worst, they'll damage her ability to believe in herself.

In his research on cultural issues, Peter Bell has identified some of the effects of cultural attitudes on counseling styles. These concepts can also be applied to outreach styles, and to agency practices as a whole. This information is important for anyone who works in a helping role. Bell gives the example of a European-American therapist working with an African-American client, but it could be a therapist or outreach worker of any culture, working with a client of any culture. Here are the categories of cultural attitude that Bell identifies:

- *The Overtly Racist Therapist:* This is the therapist who says and/or does things that are entirely inappropriate, because of his or her own prejudice. The client may react by shutting down emotionally and, in many cases, leaving treatment. No effective treatment

will take place in the presence of this dynamic.

What are some overtly racist things that a therapist might say or do?

____

____

____

At any time in your life could you have been described as "overtly racist" toward any culture? Please explain.

____

____

- *The Covertly Racist Therapist:* This therapist may or may not be aware of his or her own prejudices, and usually communicates them in indirect ways: hidden messages, body language, tones of voice, facial expressions, etc. The client sees and hears these messages loud and clear. Even if she weren't so vulnerable she couldn't confront them, because they're not stated. The client may feel confused and angry and shut down emotionally. Sometimes the client will remain in the relationship, but still carry the burden of all the unexpressed anger and confusion. As with the overtly racist therapist, no effective treatment is taking place.

  What are some covertly racist things that a therapist might say or do?

____

____

____

At any time in your life could you have been described as "covertly racist" toward any culture? Please explain.

____

____

- *The Culturally Ignorant Therapist:* This therapist is simply unschooled about the client's culture, through lack of exposure and education. He or she doesn't understand the client's culture and doesn't know how to interact effectively with the client. This therapist's mistake is the failure to admit that he or she lacks the necessary knowledge, along with the failure to get help for this lack. As a result, the client's treatment is not appropriate. The client often realizes that the therapist doesn't know what he or she is doing, which makes it more difficult to build the kind of trust and safety necessary for a successful therapeutic relationship. In some cases the client may take it upon herself to educate the therapist, a process that might place an unfair burden on the client.

  On a scale of one to ten, where would you rate your cultural experience of, knowledge of, and comfort with these elements of your client's culture:

	African-American	*Latino*	*Another Culture*

Language and way of speaking	_____	_____	_____
Community	_____	_____	_____
Family customs and structure:	_____	_____	_____
Sense of humor	_____	_____	_____
Cultural self-image	_____	_____	_____
Social structure	_____	_____	_____
Cultural values	_____	_____	_____
Definition of respect	_____	_____	_____
Cultural insecurities	_____	_____	_____
Cultural strengths	_____	_____	_____
Cultural religious influences	_____	_____	_____
Race or culture overall	_____	_____	_____

- *The Color-Blind Therapist:* This is the therapist who believes that all women have the same issues regardless of culture, and doesn't take into account the strengths and needs problems specific to the client's culture. Handed a "canned" treatment program, the client often feels left out, unrecognized, invisible. Some of her deepest, most important issues remain unaddressed.

  What are some color-blind things that a therapist might say or do? __________________

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  ____

  At any time in your life could you have been described as "color blind"? Please explain.

  ____

  ____

- *The Culturally Liberated Therapist:* This therapist is fully aware of his or her own attitudes toward all cultures, having assessed those attitudes not once, but on an ongoing basis. This therapist has done the appropriate research, gathered information, and gained education in working with the specific client populations. The client feels understood and respected, trusts the therapist's competence, and knows that she can't use her cultural experiences as an excuse for not working on getting well.

  How would you assess your present level of progress toward being culturally liberated?

  ____

  ____

  ____

  ____

What steps might you take to become more culturally liberated, especially in your work?

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Issues Faced by Many Women of Color

The types of emotional wounds that women of color sustain in childhood and adulthood are not unknown to other women, or to treatment clients in general. But it's safe to say that certain issues tend to arise more often and spring from deeper places in the lives of African-American women and Latinas. It helps to look at these issues and think about how they affect your clients. They're divided here according to the types of relationships in which they occur.

- *Relationships with service providers:* Many women of color have been the objects of prejudice and discrimination by service providers, from childhood through the present. This has damaged their ability to trust helping professionals, and their fear of the violation of any trust that might develop. If the service provider is of the same culture or race, this might or might not help. The service provider might be seen as having "sold out."

  When you begin to work with a client, try to learn or imagine how many helping professionals have worked with her in the past, and what her experience with them might have been. Especially if she comes from a disempowered culture, her fear of losing (or never regaining) custody of her children might be so intense that it gets in the way of her ability to build an honest relationship with you.

  In your clients' actions and attitudes, what signs can you see of negative experiences with service providers?____

  ____

  ____

- *Relationships with the immediate family:* In many African-American and Latino families, there are strong spoken and unspoken rules against discussing the family's business with outsiders. This can be a significant challenge for the client who has unresolved family issues that can be healed only if she betrays this deeply rooted family value. You need to explore methods of respecting this value while you help her find a way to balance it with her recovery needs. She might also fear loss of power within the family if she enters treatment and begins to change.

  How do you see these and other family-related issues in your clients' lives?

  ____

  ____

  ____

- *Mother-daughter relationships:* Especially in African-American families, the bond between mother and daughter is very important. When that bond is disturbed—in the relationship between the client and her children, or in her relationship with her own mother—there is great pain and fear. These kinds of issues must be respected and addressed in culturally appropriate ways.

  What are some of the problems that arise in your clients' relationships with their mothers, and how does this seem to affect their well-being?______________________________

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  ____

- *Relationships with the extended family:* In both African-American and Latino cultures, the extended family is vitally important. Many women feel a deepened sense of shame, for fear that their extended family will know that they are in trouble. But in many cases involving the extended family effectively can be the key to the client's successful recovery. Outreach can and must play a key role in these efforts.

  Describe your clients' involvement with their extended family. _____________________

  ____

  ____

- *Relationships with men:* In some African-American communities, historical social and economic forces have had a major impact on the roles of men. Out of necessity, women have assumed responsibility, but in some cases they have been blamed for the imbalance of economic advantage. Some men have tried to compensate for their loss of economic power by becoming controlling or abusive toward the women in their lives. Some African-American women and men struggle with issues of mutual anger, lack of respect, mistrust, and confusion about their relationships.

  In many Latino communities, men still hold quite a bit of power—economic, physical, sexual, and emotional—over women. More and more Latinas have been claiming equal power and rights, but not without quite a bit of resistance from the men. When you work with women, it's important to understand the balance of power in their relationships with men, and all the cultural and economic factors that have contributed to it.

  How would you describe your clients' relationships with men?_____________________

  ____

  ____

  What role does power play in those relationships?________________________________

  ____

  ____

- *Relationships with religion:* In many African-American and Latino communities, the church is a great source of spiritual and cultural strength. The tendency in treatment to separate spirituality and religion may not work with clients whose spirituality is so closely entwined with the religion in which they were raised. It's important to be aware of these factors, and to respect each client's personal definition of spirituality. It's

equally important to consider the churches of your clients' cultures as possible sources of help and support.

Describe one client's relationship with the faith community in which she was raised.

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- *Relationships with themselves:* Many clients who have been victimized by prejudice and discrimination have learned to believe the lies that they were told about themselves. Many people carry the shame of their culture's and/or their gender's entire history. They might not mention these beliefs, or even be aware of them, but the shame can sabotage your best efforts to help. And how are they to find their identity if their history or cultural traditions have been objects of shame, or have been dismissed as unimportant? It's important for all helping professionals who work with women of color to help and encourage them to: 1) experience their cultural traditions and celebrations; 2) learn the history of their cultures, families, and communities; and 3) develop healthy and effective strategies for coping with racism.

  How do issues of self-esteem affect your African-American and Latina clients' lives?

  ____

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  ____

- *Relationships of women within the Latino community:* Many women of color struggle with their relationship to the dominant American culture. Among Latinas in particular, there are various different degrees of aculturation. Women who have recently arrived from Mexico, for example, may be much less assertive and have a lesser potential for independence compared to Mexican-American women who were born in the U.S., or who have been in this country for many years.

Strengths and Resources in African-American and Latino Cultures

It will take much more than a page in this manual to acquaint you with all of the strengths, resources, and resiliencies available in your clients' cultures of origin. If you're already familiar with these assets, you can play an important role in your clients' re-education process. If you're not familiar enough, you can learn a step ahead of your clients. What is important is that you learn, and that you affirm the strength and beauty that they can find within themselves and within their cultural traditions.

The cultural stereotypes about African-American and Latino communities, families, and women can be powerful agents in destroying hope and the will to survive. Your clients need an equally powerful antidote in order to succeed in recovery. But it can't just be a denial of the stereotypes.

Instead, it must be a search within the cultures themselves, to find the strengths that are sometimes hidden by circumstance, but are so apparent to anyone willing to see them.

In many ways it means building a vision of a healthy African-American or Latino family. There are many examples out there waiting for recognition. The following are some elements of healthy families, from the work of Robert Hill. Although Hill was writing specifically about healthy African-American families, many of these strengths can be found in healthy Latino families as well.

- *Strong bonds and shared identity:* African-American and Latino families are known for the strength of their connections, within the immediate family and in the much larger extended family. Used for recovery, this deep love and loyalty can be powerful resources.
- *High achievement orientation:* There are many healthy African-American and Latino families who wouldn't even think of letting their children drop out of school or not finish college or trade school. Most families take great pride in their members' achievements, and many have much to be proud of.
- *Flexibility in family roles:* This is a particularly strong asset in African-American families, where flexibility has often been necessary to survival. It's important to avoid putting too much responsibility on older children, but the family's flexibility should still be recognized as an important strength.
- *Strong religious orientation:* Much strength has come from families' active involvement in religious and spiritual life. This can be put to the service of recovery.
- *Creativity:* Both African-American and Latino cultures are full of art, music, poetry, innovation, and life. The very struggles that cause so much pain give rise to beauty.
- *Communal values:* In contrast with the dominant culture's focus on individualism, most African-American and Latino communities have a strong sense of collective responsibility. These are well reflected in the seven principles of Kwanzaa (the Nguzo Saba), taken from the work of Dr. Maulana Karenga. The seven principles are Umoja (unity), Kujichagulia (self-determination), Ujima (collective work and responsibility), Ujamaa (cooperative economics), Nia (purpose), Kuumba (creativity), and Imani (faith). The celebration of Kwanzaa was developed as a celebration of African-American values and principles, but these principles can give strength to other clients, families, and communities and communities as well. Communal values can be life saving for one whose very survival depends on going beyond her own individual power and combining her strength with the strength of others.

How do you see these and other strengths reflected in your clients' cultures of origin?

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How can you use words to tell clients about your belief in, and appreciation of, these strengths?

____

____

____

How can you convey your belief in these strengths without using words?

____

____

____

Reading Resources

Bell, P., with Donna Peterson (1992). *Cultural Pain and African-Americans: Unspoken Issues in Early Recovery.* Center City, MN: Hazelden.

Hill, R. (1971). *The Strengths of Black Families.* New York: Emerson Hall.

Karenga, M. (1988). *The African-American Holiday of Kwanzaa: A Celebration of Family, Community, and Culture.* Los Angeles, CA: University of Sankore Press.

4.2 Empowering Vs. Enabling

Learning Objectives

1. Discuss the two concepts "empowerment" and "enabling" and the differences between them.

2. Discuss some common changes in the level of client need during involvement in Project SAFE, and how those changes affect the outreach worker's empowerment role.

3. Identify instances of empowerment, enabling, and abandonment.

Empowerment and Enabling

As you've heard and probably experienced, "Empowerment" is a process of learning how to find the strength, courage, and other resources needed to meet life's challenges. A client's empowerment process often begins when she meets a woman who can give her the nurturing she needs without trying to use or manipulate her—a woman who also stands as an example of strength, courage, and other resources in action. In empowerment, the main message is, "People like us can survive and succeed."

"Enabling" often starts out looking like empowerment, because they both seek to nurture the client and build safety. But enabling is in many ways the opposite of empowerment. It ignores the client's own resources and responsibilities, and seeks to "do for" the client long after she's ready to start testing her wings. The message of enabling is: "You won't survive unless I do these things for you."

Project SAFE clients, with their deep wounds and extreme levels of need, make it hard to tell the difference between empowerment and enabling. The outreach worker's role is by nature a nurturing one. It requires Tough Love—sometimes heavy on the Love and light on the Tough. Outreach workers with a background in traditional treatment have sometimes had to try things they once believed they weren't supposed to do—like show up on a client's doorstep for weeks in a row before she even decided to enter treatment—and found that those things meant the difference between life and death for the client.

Think about the process of empowerment that you've gone through in your own life. What are some of the things that others have done—or not done—that have left you feeling more powerful, more capable, more sure of your ability to succeed?

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____

Based on those experiences, how would you personally define “empowerment”?

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Now think about things that others have done—almost always with good intentions—that have left you feeling a little more dependent on them, a little less capable of doing it for yourself. What are some of those things?

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Based on those experiences, how would you personally define “enabling”?

___

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The Helper's Needs

One difference between empowerment and enabling has to do with the needs of the person who's helping. It's in our basic nature as human beings to need to help others (although not everyone is in touch with that part of our nature). We get good feelings from giving, and from seeing the people we're helping get better and succeed. When we take part in the healing of another human being, that healing process heals something in us, too. This is the “selfish” side of empowerment. We get a spiritual power from it that leaves us stronger and more joyful.

Think of a time when you've done something that was truly empowering for a client or another person—left her stronger, more independent, and more confident. What thoughts did you have just before taking that action?

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___

What feelings did you have just before taking that action?

___

___

How did you feel after that incident?

___

___

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Like empowerment, enabling also has its selfish side. But in enabling, the dominant need is for control. We don't trust the person to do the things that she needs to do for herself, so we do them for her. We're afraid she'll do them wrong, she won't do them quickly enough, she'll reflect badly on us, etc. We might even be afraid of her pain, and all the uncomfortable feelings it raises in us.

The power we get from enabling is not spiritual power. It's a kind of psychological power that may give us more control, but it doesn't leave us stronger. It actually leaves us weaker, because it has fed our fears and insecurities. And we can do all of this with absolutely good intentions, and no desire to enable or make anyone weaker. Alcohol and drugs aren't the only things that are "cunning, baffling, and powerful."

Think of a time when you've done something that turned out to be enabling—left someone a little more dependent and a little less sure of her strengths. What thoughts did you have just before taking that action?

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____
____

What feelings did you have just before taking that action?

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____

How did you feel after that incident?

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____
____

In the future, what kinds of thoughts and feelings might tell you you're about to do something enabling?

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As one outreach worker said, you can tell when you've crossed the line from empowerment to enabling when a client stops saying "I tried to do . . ." and starts saying "I need you to do . . ." all the time. "I tried" tells you that you've been encouraging her to find her own resources. "I need" tells you that you've been spoon-feeding her as if she were a child.

The Importance of Timing

As if making this distinction weren't hard enough, there's the question of timing. At different

times in a client's progress, the same action on your part could be empowering or enabling. Think of a tiny baby in your arms. Her neck muscles aren't strong enough to hold her head up, so you have to support her head with your hands. At a certain point in her development you need to let go so she can practice using those neck muscles and strengthening them.

In the early days, a resistant client will swear she needs nothing from you. Then as she gets involved in the program and starts to trust you, her intense dependency needs will show up. Her fears are enormous. Her skills are unformed. She truly needs you to help her with things that most people take for granted. More than that, she desperately needs to feel safe needing someone, and to have that person respond to her needs and not use her or punish her. She never got that as a child. Letting her need you is part of the re-parenting process that will help her grow up. It is an opportunity for you to fill an unmet need from the clients childhood so that she can progress in recovery.

Describe a client in this dependency stage of recovery.

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How do you feel when you work with this client?

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After a time, you need to back off a little and let her find ways of doing things for herself. Finding this point in the process can be tricky, because she may still have strong fears and still want to rest in that safe dependency. Or she may feel like she's ready to do it for herself, but still needs you right there in case she falls. She'll be scared at first, but after a few successes, she'll realize that she can handle it. Then you'll take on the role of a proud parent, applauding her success.

There's no sure formula that can tell you when to start letting go. It depends on many things: her circumstances, her motivation, the depth of her wounds, her additional disorders, etc. Sometimes your logic will tell you when to let go, but more often you might have to listen to your gut feelings, or even have a talk with your supervisor.

Describe this gentle "backing off" process with a client.

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How did you know when it was time to start letting go (and/or putting the supports back in place)?

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How did this process feel to you?

And finally, it's important that this process of letting go not feel like abandonment to the client. Most clients' abandonment issues are so deeply rooted that no amount of time in recovery will completely erase them. A client may graduate from Project SAFE, and from your intensive involvement in her life, but she doesn't graduate from her relationship with you.

Many outreach workers say that their clients still call them from time to time after graduation, when they need help or when they have major successes to report. This ongoing involvement in their lives gives clients more and more evidence that they matter to you and that they're not alone.

Telling the Difference

Faith is on a waiting list to enter treatment at Project SAFE, and you're her outreach worker. This is your third home visit. Her apartment is a mess, with dirty dishes piled up in the sink and roaches crawling everywhere. She's been depressed, and when you showed up at 11:00 she was still in bed and you could tell she's been crying. Her bills haven't been paid, her electricity has been shut off, and there's an eviction notice on her door. She asks you if you could get someone to pay the bills for her.

What might be an enabling response?

What might be an empowering response?

What might be an abandoning response?

Leisha is almost through her treatment, and she's been making progress and getting stronger. You're driving her home, and she's the last one you're going to drop off. She's talking about all the things she has to do—bills to pay, appointments with doctors and social service personnel, etc.—and how hard it is to get everywhere on public transportation with no money or tokens.

You get the feeling that she wants you to offer to take her to these places, but she hasn't asked you.

What might be an enabling response?

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What might be an empowering response?

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What might be an abandoning response?

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4.3 Minimizing Manipulation

Learning Objectives

1. Discuss the concept of manipulation as a survival skill.
2. Identify some common types of manipulation that clients use, and discuss ways of responding to those types of manipulation.
3. Discuss the development of healthy survival skills as the most effective antidote to manipulation.

Manipulation as a Survival Skill

Much has been said in this manual about the painful, humiliating, and sometimes tragic circumstances of clients' early lives and their years of using. These experiences have left clients with a number of deeply rooted symptoms, ranging from substance abuse to denial to fierce emotional outbursts. All of these symptoms had the same origin: They started out as ways of surviving, and they used to work very well.

For most clients, another critical early survival skill was manipulation. Simply put, manipulation is whatever we do to get what we want (or get away from what we don't want) when we can't get it in direct and honest ways. Manipulation is the all-purpose tool of the powerless. It is absolutely necessary for children's survival in abusive and neglectful situations. It is absolutely necessary for survival on the street, and in the using culture. Sometimes manipulation is a matter of conscious choice, and sometimes it's not. But it always feels completely necessary to the person who's using it. This is usually true long after the person has left the situations where manipulation was necessary for survival.

Think of a current client you know fairly well. Think of her childhood, her using years, and all the relationships she's told you about. What were some of the circumstances that made her powerless?

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What kinds of manipulation would she have had to use in order to survive, physically and emotionally, in those environments?

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What kinds of manipulation has she used (or tried to use) with you and other Project SAFE staff?

How would she feel if she woke up one day and she couldn't use any of those manipulation skills?

Would she simply get honest all of a sudden, or would she reach for another survival skill learned in her early years or her using years? What survival skill would she probably use?

Even after skills like manipulation are no longer necessary for physical survival, and even after they stop working the way they used to, the client still has an emotional need to use those skills. Many psychologists believe that, when a client's main survival skill is taken away, she'll reach for a more primitive survival skill. In the case of most Project SAFE clients, the arsenal of survival skills contains some very dangerous weapons, including substance abuse and violence.

That's all well and good, but what about the outreach worker who has to listen to all of the manipulation? What about all the lies and excuses and guilt trips and mind games? Don't those things get in the way of recovery? Absolutely. At its best, Project SAFE is a world in which manipulation doesn't work. But it also needs to be a place where manipulation stops being necessary, because she's finally safe. She'll test that world again and again, and it needs to keep coming up safe.

What are some ways in which Project SAFE is emotionally safe for clients?

What else could be done to increase clients' emotional safety?

The Many Faces of Manipulation

As staff, it's your job to keep from falling for the manipulation, and at the same time show by your example what an honest, non-manipulative person can accomplish. You become the structure in which the client can re-form her character and her ways of communicating. Here are a few forms of manipulation commonly used by clients:

- **Triangulation:** Triangulation is a handy word for those cases in which one person goes behind another's back and talks to a third person in order to get something or to discredit the other. As one outreach worker said, ". . .like kids play parents—mom against dad—they'll play outreach worker against case manager."

  Sylvia didn't like the answer that her outreach worker gave her when she asked for special permission that was up to the outreach worker to approve or deny, so she went to her case manager and asked her to overturn the outreach worker's decision. She told the case manager that the outreach worker had personal reasons for making the decision that she made, and that the outreach worker had said some negative things about the case manager in the past.

  How should the case manager respond to Sylvia's request? How should both staff members handle the situation?

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- **Limit-Testing:** This can be anything from taking the seat belt off in the van, to asking for special favors that she knows are against the rules, to yelling and cussing in situations where it's not okay to yell and cuss.

  What are some gentle but firm ways of setting and defending limits?

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  How do your methods change when it's the 20th time she's tested this particular limit—the 20th time today?

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- **Lies and Excuses:** Outreach workers report high levels of imagination among many of their clients. Some lies and excuses are transparent; others need to be checked out. As one outreach worker said, "Don't even get into the excuses."

  What do you do or say when a client is telling you something important that you know isn't true?

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What do you do or say if you're not sure whether or not it's true?

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What might make this client feel safe enough to start telling the truth?

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- What's another form of manipulation that clients often use?

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What's your best response to this kind of manipulation?

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Saving Face

One factor that complicates the search for the appropriate response to manipulation is the importance of not shaming the client. She needs to save face, even though at the moment it's a false face. People who rely on manipulation sometimes don't realize what they're doing, and usually don't realize that you know what they're doing. A large amount of pride is invested in keeping up the front. It's tricky to let them know you see through their games, and at the same time convey respect for the person underneath the games.

What are some things you can say or do to help your clients save face while you refuse to be manipulated?

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Healthy Survival Skills

One of your most important roles as an outreach worker is your ability to model healthy survival skills. You are living proof that these skills work. Only as your client learns these skills, practices them, and gets comfortable with them will she feel safe in letting go of manipulation.

Here are a few healthy survival skills:

- **Assertiveness:** This is the opposite of manipulation. It's asking for what she wants and needs, pure and simple. The client needs to know that assertiveness isn't the same as aggression. It's a cooperative act.

  What are some ways of modeling assertiveness in your relationships with your clients?

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- **Taking Responsibility for Mistakes:** This skill can be an enormous relief to someone who has spent years making excuses, dodging blame and guilt. The client needs to know that, when she takes responsibility for having made a mistake, the world doesn't end. Whatever the consequences of the mistake might be, they're probably less painful and less energy-consuming than the process of dodging responsibility.

  What are some ways of modeling responsibility-taking in your relationships with your clients?

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- **Relaxation Techniques:** Fear, anxiety and anger are powerful forces leading toward any or all of the unhealthy survival skills. The client can learn to deal with the perceptions that lead to fear, anxiety, and anger (often perceptions of emotional danger) and the physical effects of these states (see the last section of the module called "Safety Tips for Outreach Workers"). As she questions her perceptions—and brings down the physical signs of fear, anxiety, and anger—she'll feel less threatened.

  What are some ways of modeling relaxation techniques in your relationship with your clients?

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What are some other healthy survival skills that have been helpful to you or other people you've known, and how can you model these skills in your relationships with your clients?

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4.4 Domestic Violence

Learning Objectives

1. Discuss the current trends among clients where violence, and domestic violence in particular, is concerned.
2. Identify some of the driving forces behind domestic violence and some of the patterns that it takes.
3. Discuss some of the risk factors for violence committed against others.
4. Discuss the outreach worker's responsibilities and role limitations where domestic violence is concerned.

Current Trends

Outreach workers and other Project SAFE staff have been noticing that domestic violence is becoming a larger and larger issue for clients. Most of the perpetrators of this violence are paramours who are themselves addicted to alcohol and other drugs. Some related trends:

- More women come from situations in which violence was an approved way of improving status and solving problems.
- Clients and the people in their lives are more and more desensitized to violence.
- More clients are involved in gang activity and carrying weapons.
- More clients have been assaulted by their paramours, and more have assaulted their paramours.
- More threats and confrontations are taking place among clients.
- More threats have been made to Project SAFE staff members.

If you've been doing outreach work for a while, what evidence have you seen that either supports or doesn't support these trends?

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What factors in clients' past lives might be increasing their risk of domestic violence?

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What factors in their paramours' past lives might be increasing their risk of domestic violence?

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What factors in their communities might be increasing clients' risk of domestic violence?

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What factors in society as a whole might be increasing clients' risk of domestic violence?

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The Face of Domestic Violence

What do you see as the strongest forces or motives that lead one partner to use violence (physical, emotional, or sexual) against another?

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Where do these forces and motives come from, in your opinion or experience?

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What do you see as the strongest forces or motives that lead a client to stay in a situation where she's being abused, physically, emotionally?

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Where do these forces and motives come from, in your opinion or experience?

Many people believe that someone who uses violence against another is being driven by fear. That fear was often born long ago, in childhood—often in situations where he or she was abused or watched someone else be abused. In many cases those early experiences actually changed the way the person's brain functions. Those changes in brain chemistry make it harder to use self-control, and easier to misinterpret others' words and actions as threatening. They might not believe that others are going to hurt them physically. Instead, they might fear losing face, losing what they have, or not getting what they want or need.

Many people are taught that the only way to get relief from this fear is to try to control other people. Violence is one way of controlling people. What are some other ways?

Outreach workers speak of certain points in clients' recovery where their risk of getting beaten up by their paramours increases.

- One of these times is when clients get involved in treatment and start cleaning up and paying attention to how they look.
- Another key time is when clients begin to feel more independent, speak in more independent ways, and take care of their business.
- A third key time is when clients realize how destructive their relationships with their paramours are and start trying to get out of these relationships.

In your opinion, what is it about these times that increases the paramours' likelihood to use violence?

Recognizing the Potential for Violence

Violence is unpredictable, but it's often possible to tell whether or not a particular person shows a high risk of using violence against others. The following is a list of risk factors that have been found in people who have substance abuse histories and have used violence against others. As

you look at this list, think of the substance-abusing male paramour of a client, and see how many of these items you might check.

____ In childhood, he experienced abandonment, brutalization (severe physical abuse), and horrification (watching others be abused). These acts began early, happened over a long period of time, and/or were perpetrated by more than one person.

____ He has some history of setting fires, cruelty to animals, and bed-wetting in childhood.

____ He has a past history of aggressive and violent behavior.

____ He has a substance-related organic disorder that is lowering his level of mental functioning.

____ He has been diagnosed with, or shows symptoms of, a serious psychiatric illness that is associated with increased risk of violence.

____ He is currently showing signs of paranoia; feelings of being persecuted; and ideas that, if he acts them out, might result in violence.

____ He is very immature, has low self esteem, is very impulsive, and engages in risk-taking behavior.

____ He is jealous, controlling, and very sensitive to rejection.

____ He talks about his fears of "blowing up" or losing control.

____ He has no social supports, or has social supports that would encourage aggression.

____ He has no personal values strong enough to curb his violent urges.

____ He has made a specific threat toward an identified person.

____ He has guns or other weapons, or has access to them.

These are important factors to keep in mind in deciding whether or not you're safe in the presence of this person. You can also use them as guidelines in taking stock of the risk of violence by a client. These are important factors to talk about with your supervisor and any other staff who work with this client or paramour. The risk of violence is not one to ignore.

Your Responsibilities and Limitations

As much as you want to be able to keep your clients safe from any harm, there's only so much you can do if she's hooked up with a violent partner.

Here are a few steps that other outreach workers have taken:

- Bring in a speaker on domestic violence, possibly from a local hotline or shelter, to talk to staff and clients.
- Play videotapes about domestic violence for groups of clients, to show them that they're not unique and that there are ways of increasing their safety.

- Tell clients about local domestic violence shelters and take them to those shelters if they request it.
- If a client talks about domestic violence that is going on in her life, suggest that she tell her counselor about it so they can work on it in treatment, and mention it to the counselor yourself.

What are some other steps you might take?

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What steps would be beyond the limits of your role as outreach worker?

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What steps would be outside your personal comfort zone?

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If your client is living with or is visited by an abusive paramour, and if you or anyone else gives her any written materials on domestic violence, **make sure she doesn't take them home and leave them where her paramour might find them.** You might offer to keep the materials in the van for her. If she must take them home, strongly suggest that she hide them at the bottom of a Kotex box or a Tampax box. Most other hiding places—underwear drawers, coffee cans, etc.—aren't safe. Explain to her that violent partners tend to get more violent if they think their victims are thinking about leaving.

Victims of domestic violence tend to make up their mind to leave many times, and then return many times to the violent situation. Why do they go back? Recovery from victimization is a developmental process very much like recovery from addiction. Sometimes it takes several tries,

and there's just a little progress each time.

Consider the case of Rhonda, who has been in a relationship with Paul for several years. She's left him seven times, and come back. The violence has been escalating as she's made progress in treatment. He beat her up badly last night, and she's really fed up. She's been getting information on shelters and she has a shelter all picked out. She asks you whether or not she should leave. What do you say?

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Some domestic violence counselors warn others in helping positions **not** to tell the client to leave the abusive partner, even if she seems ready to leave. This is because she's likely to change her mind again, either before or after leaving. When she does change her mind and decide to stay with him, she'll still remember that you told her to leave. She'll feel you judging her decision to stay. Part of her trust in you will be damaged. It's better to let her know it's her decision to make, and to urge her to talk to her counselor and a domestic violence counselor.

One of the comforts of the outreach worker's role is that you're not the counselor. You're not the final authority on the client's well being. You're the one who is there for her, who sometimes becomes part of the miracle because of your caring and consistency. But you don't have to save her. You can't save her. You can take care of your own safety and show her, by example, how to care for herself.

4.5 Safety Tips for Outreach Workers

Learning Objectives

1. Discuss a number of ways of getting information about the level of danger in a situation.
2. Discuss a number of measures that outreach workers have suggested to avoid dangerous situations or lower the level of danger.
3. Examine how fear affects your judgment and responses, and discuss ways of lowering the effects of panic and improving your responses in potentially dangerous situations.

Danger Zones

If you've been in outreach work for a little while, you know that many clients live in neighborhoods that sometimes seem like battlefields. Many clients' home environments also seem like battlefields, particularly if they're living with addicted partners with a history of violence. Even the inside of a client's mind can seem like a battlefield, with so many intense and conflicting thoughts, needs, and emotions.

You're an outreach worker, not a soldier, a super hero, or a sacrifice to the cause. As important as the client's well-being is, it's part of your job to put your own safety first. Avoiding a dangerous situation doesn't make you a coward or a failure. It makes you available to keep trying and helping, with this client and the next.

In order to avoid danger, you need to know about it. What are some ways of getting information about the danger you might face in a particular situation?

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What steps can you take to get this information from the referring DCFS case worker?

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What steps you take to get this information from your supervisor or other Project SAFE staff?

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How might you get this information from your own observations as you approach the situation?

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How might you get this information from your own body (your intuition or gut feelings)?

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The following exercises are designed to put you more in touch with your gut feelings of danger. Imagine yourself in these situations, and let yourself feel what you would be feeling.

> *You're going to visit a client in a neighborhood you've been in several times and never seen any trouble. It's a housing complex. There are people of all ages on the streets. There are elderly men sitting together on the lawns. There are children playing in the playground. Nobody seems to be paying attention to you as you pull up in your car.*
>
> What feelings do you have, in your stomach or chest, as you picture yourself in this situation?
>
> ____
> ____
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>
> *Now you're visiting the same client the following week. The elderly people and children you usually see here are gone today. There seem to be many people on the streets, mostly men, and many of them seem to have been drinking. The neighborhood seems louder than usual, and you feel a sense of something in the air, but you can't identify what it is. A group of men watches you closely as you pull up in your car.*
>
> What feelings do you have, in your stomach or chest, as you picture yourself in this situation?
>
> ____
> ____
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>
> *Now the next situation. You're in a large apartment building, approaching the door to your client's apartment. You can't hear any voices inside the apartment, just the sound of the TV.*
>
> What feelings do you have, in your stomach or chest, as you picture yourself in this situation?
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> ____
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> *You're in the same apartment building, approaching your client's door. You hear very loud voices from inside the apartment. You recognize them as the voices of your client and her paramour. You can tell from the sounds that they're having an intense fight that is both verbal and physical.*

What feelings do you have, in your stomach or chest, as you picture yourself in this situation?

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At times we've all found ourselves denying those uneasy gut feelings, out of a sense of duty or a fear of being silly, and regretting it later. When you've denied these feelings, what have you usually told yourself?

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Next time you find yourself denying your gut feelings in this way, what can you tell yourself to counter that denial?

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Safety Measures

Here are some pieces of advice from outreach workers and supervisors, some of whom have learned the hard way.

- "You have to watch the area, to see what's going on, before you even attempt to get out of the van."
- "Cruise the area and find out when it's a safe time to visit. Ask the client. 'I need to do this for 90 minutes every week, so you need to tell me when it's safe.' We've had women walk over to the drapes and give us a thumbs up, saying 'Come on in, it's okay,' or thumbs down or some other gesture to say, 'Get out of here!' We're going to respect your household; just keep us safe. If we notice something is going on, we'll say, 'Look, I noticed when I came in that this was going on and I'm not feeling comfortable. Can we go back to the office?"
- "I'd strongly encourage the outreach workers to trust their instincts. If you're feeling unsafe, leave. We'll go back later. We had an incident with an outreach worker who had walked through a gang of six men standing in front of a door. She mentioned later that she was a little nervous. I said, 'Go in the morning when the gang-bangers are asleep. You don't have to do it right then. She'll still be there and she'll still be getting high'."
- In general, home visits are much safer in the morning than in the afternoon.
- Don't go into dangerous areas alone. If a situation isn't safe to visit alone, visit in a team. If your site has any male outreach workers, work in a male-female team. If you tend to

panic in dangerous situations, tell your partner about it and tell him or her what to expect from you and how to get you out of it.

- If you're not ready to handle going into a particular situation, tell your supervisor about it. Someone else can handle that situation.
- Learn about the unofficial "rules" in public housing and take them seriously. Even if you used to live there, or go in there to buy drugs, it's different now that you're an outreach worker. "Coming in there as a professional, all of a sudden that whole idea turns around and you're the enemy."
- Public housing complexes aren't the only dangerous areas. Beware of houses that look abandoned, with boards on the windows or no sign of life inside.
- Pay attention to the racial makeup and feelings in the area. No matter what race you are, if you're the only one of your color in a racially tense neighborhood, you're in danger.
- Don't get boxed in. Always leave yourself an escape route in case things get violent. For example, if you're going into a house in a situation that might be dangerous, don't pull into a driveway where someone else could park behind you and block you.
- Don't wear expensive jewelry or clothes, don't carry a lot of money, and keep a secure hold on your purse (if you have to carry one).
- Learn and respect the cultural rules about eye contact, body language, speaking to strangers, etc. Learn the hidden language underneath these "languages," so you don't "say" the wrong thing to the wrong person.
- Always seem as confident as you can—by your look, your walk, your way of talking. Talk to your supervisor and your co-workers about this, and ask them to watch you on home visits. If you can't act confident in a situation and make it convincing, you're not the right one to go into this situation at this time.
- Even police officers will tell you that a domestic violence situation is the most deadly one for an outsider to enter. You can get attacked by either partner, or by both partners.
- Always keep a mobile phone with you, and a beeper, if you have one. If your program doesn't provide phones, try to get them. If your program can't afford them, volunteer to work on a plan to raise the money. If you know someone whose phone you can borrow (possibly your supervisor), borrow it when you pick up clients or make your home visits.
- The van can be a "hot" zone too, while the clients are being transported together. For example, one client may be seeing another's paramour, and sparks might fly. Clients who have fights in the van—particularly physical fights—put everyone in danger. The best way to deal with these issues is to try to prevent them. Have a strict "no confrontation" rule in the van. Tell the women to save these issues for group. If you know that two clients are having a conflict, don't let them sit near one another in the van. And if fighting of any kind starts, pull over until you can stop the fighting.
- "If someone is out of control, if someone is angry and shouting and distracting you from driving, you have a perfect right to pull over and say, 'You need to settle down before we can move any farther'."
- In transporting a dual-diagnosed client who might have violent tendencies, keep the

client near the front of the van where you can keep an eye on her. It's important to have these clients keep their purses on the van floor, so you can see if they start to reach for weapons.

- The use of seat belts in the car or van is an important safety issue. Some clients will try to take them off repeatedly during the ride, or their children will take them off and the mothers won't enforce the rule. Make sure you monitor this carefully and keep reminding them of the seat belt rule. If necessary, you can stop the van until they put the belts back on. If a client is pregnant she may have a strong desire to remove the seat belt for comfort. If possible, have her ride in the front seat so you can watch her more closely.
- Other rules are also important for keeping order and safety in the van or car. These include no smoking, no walking or dancing while the van is moving, no yelling out of the van window, no beating on the window, and no honking the horn to get the attention of people on the street or sidewalk. See the module on "Providing Transportation."
- You're responsible for keeping the van or car in good working order. Make sure it has its routine maintenance visits, and get problems checked and fixed before they turn into breakdowns. Make sure you know how to change a flat tire and have a good spare.

What safety tips of your own would you add to that list?

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The Effects of Fear and Panic

One reason it's so important to avoid dangerous situations is that, once we're in danger, we can't think as well as we can the rest of the time. The physical effects of fear actually keep us from communicating with the parts of our brain that would otherwise tell us what our options are, what we should say, and what the consequences of our actions might be. And all this is happening at a time when we **really** need to know what our options are, what we should say, and what the consequences of our actions might be!

When you sense danger—physical danger or emotional danger—your body automatically starts pumping out quite a bit of adrenaline. You might know that's happening because you get certain physical symptoms. Sometimes your heart starts beating faster, your face gets red, your arms start to tingle, and you can actually feel the panic rising up through your stomach, into your chest, and up toward your throat. You might have a funny taste in your mouth, or hear the blood pounding in your head.

This reaction to fear is called "flooding," because your brain is being flooded with adrenaline. Flooding doesn't just happen when you're afraid. It happens when you're angry, too. It's interesting that the physical and neurological symptoms of fear and anger are the same. We know the difference between the two because of the way we interpret the situation.

Think of times when you've experienced flooding. What physical symptoms do you tend to get?

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When your brain floods with adrenaline (in the brain it's sometimes called "noradrenaline" or "norepinephrine"), several changes take place. Our brains function by having messages travel down what are called "neural pathways." In flooding, the adrenaline blocks the pathways that lead to the part of the brain that forms language. So we can't find even simple words that are easy to find at other times, or understand other people's words. The adrenaline also blocks the pathways that lead to the part of the brain that thinks of options and alternatives, and the part that predicts the consequences of our actions.
So we can't go to our language centers for help, or to the higher logic centers that will tell us what we can do and what will happen when we do it. What's left? Where can we go? Straight down, into the primitive parts of the brain that only know how to fight, freeze, or flee (run away). Usually we tend to choose one of these responses over the others, based on our own experiences and what worked best for us when we were children.

When you're flooding, is your strongest urge usually to:

_____ fight (physically or verbally),

_____ freeze (feel emotionally or physically paralyzed), or

_____ flee (to run or walk away physically, or to escape into your mind)?

What do you usually do when you get that urge?

____

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How effective is this response in dealing with the danger you find in your work?

____

What response, if any, would you rather have to these situations?

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Four things are important to remember when you feel the physical signs of flooding:

1. This is flooding.
2. The adrenaline has taken over my brain, and I won't be able to think clearly as long as I'm flooding.
3. I can bring the flooding down so that I'll be able to think better.
4. The people I'm dealing with are probably flooding too. They probably can't think clearly either, and they probably won't understand what I say to them, no matter how smart they are—especially if what I'm saying requires that they use their logic or common sense.

To bring down your own flooding, try breathing slowly and deeply. Do some kind of large-muscle exercise. That helps clear the adrenaline out of your brain. If possible, do some running or fast walking, although sometimes the situation won't let you do this. But even if you can't safely make any visible movement, you can exercise your large muscles by pushing very hard on a wall, trying to pick up the chair you're sitting in, or pressing your arms very hard against your side. Do this for a few minutes.

Think of a past situation in which you were flooding and had trouble thinking clearly. What could you have done in that situation to bring down the flooding?

____

____

When you're with people who are flooding:

- Don't use any words, tones of voice, looks, or body language that they might see as aggressive (like pointing a finger, leaning toward them, putting your hands on your hips,

or shaking your fist).

- Don't show fear, through your voice, your face, or your body language (like clutching yourself, wringing your hands, looking down, or letting your eyes dart back and forth).

When you talk to people who are flooding, speak calmly, in a soft tone, in the lower notes of your voice, with no panic or hard edge to your voice. If you use any other tone of voice, they're going to interpret it as an attack—or an invitation to attack you! Their bodies are telling them to interpret you that way, and their brains are out of reach at the moment. It's important to practice this tone of voice in ordinary times, so that you'll be used to it when you really need it.

4.6 Ethical Issues in Providing Outreach Services to Women

Learning Objectives

1. Identify three basic questions that are part of effective ethical decision making.
2. Apply a model of ethical decision making to case studies that involve the following issues: confidentiality, self-disclosure, dual relationships, and duty to warn/intervene.

Definitions

An outreach worker's decisions and actions might be judged in a number of ways by a number of people and agencies. Some of them will be judged right or wrong, wise or unwise, successful or unsuccessful. These judgments often have to do with the ethics of your profession. In the space below, define the following terms, making clear the differences among them:

Immoral:____

____

Illegal:____

____

Unethical:____

____

Professionally
Inappropriate:____

____

This module is about the third one of those concepts, the idea that an action is ethical or unethical.

When we speak of ethical or unethical behavior, we're generally speaking about how to avoid doing harm to individuals, institutions, and communities—whether or not that harm is intended. Service relationships have a high potential for harm because of the unequal power that exists there: the client's vulnerability and the staff person's potential power to do harm.

The relationship between an outreach worker and a client is different from other relationships the outreach worker may have, because the service relationship is *fiduciary*. This means that the

outreach worker has taken on a special duty to and obligation for the care of the client. By taking on the role of outreach worker, you've pledged to the client to act in a highly professional manner and in the client's best interests. Many difficult ethical issues can arise as one tries to fulfill this fiduciary promise.

In medicine, unintentional harm caused in the process of trying to help is referred to as an *iatrogenic* illness—a physician-caused or treatment-caused injury. The goal of this section is to lower the risk of any iatrogenic effects that could result from the delivery of outreach services to women.

A Model of Ethical Decision Making

For the purposes of this training, you'll be introduced to a three-step model of ethical decision-making. In this model, you ask three questions in the face of an ethical question, problem, or dilemma:

1. *Who will gain and who will be (or could be) hurt in this situation?*

   This question reflects the understanding that the actions of an outreach worker have the potential to harm a number of parties: the client and her children, the outreach worker, the agency (which could include both the service agency and the funding agencies), the profession, and the broader community. This question also reflects the understanding that the interests of one party can conflict with another. Clarifying these interests and their potential conflicts is the essence of ethical decision-making.

2. *Are there any universal values that would apply to this situation? What course of action would each value dictate?*

   In White's 1992 book on ethical issues in addiction treatment, he identified the following seventeen values that repeatedly appear imbedded within the ethical standards of professional disciplines.

   Universal Values in a Professional Codes of Ethics

   - Autonomy (Help people find freedom in fulfilling their personal destiny.)
   - Beneficence (Help others.)
   - Competence (Be knowledgeable and skilled.)
   - Conscientious Refusal (Disobey illegal or unethical directives.)
   - Diligence (Work hard.)
   - Discretion (Respect confidentiality and privacy.)
   - Fidelity (Don't break promises.)
   - Gratitude (Pass good along to others.)
   - Honesty and Candor (Tell the truth.)
   - Justice (Be fair; distribute by merit.)
   - Loyalty (Don't abandon.)
   - Non-maleficence (Don't hurt anyone.)

- Obedience (Obey legal and ethically acceptable directives.)
- Restitution (make amends to anyone you've injured.)
- Self-interest (Protect yourself.)
- Self-improvement (Be the best that you can be.)
- Stewardship (Use resources carefully and appropriately.)

3. *What laws, policies, procedures, or other directives would apply to this situation?*

   The third question you'll ask in sorting through an ethical dilemma focuses on the kinds of guidelines that may already exist for this exact purpose. These guidelines might include everything from state and federal laws and regulations, to agency policies and procedures, to memos or spoken instructions from your supervisor related to this particular type of situation.

As you follow those steps, it's suggested that you use the following general guidelines in situations that pose the greatest risk of injury:

1. Get advice from appropriate people in your agency as soon as possible.
2. When advice from outside authorities is necessary or appropriate, seek such advice.
3. Document both the ethical issues that you've identified and your reasons for making those decisions.
4. Review the incident later in order to see what you or others can learn that can guide staff in future situations.

The following are ethical case studies that can be used to test this model of ethical decision-making.

Ethical Case Studies

Credentials

There is a general ethical rule that states that professionals must accurately represent their education, training, and experience. Joan, an outreach worker who hasn't had any formal training in counseling, often tells new people that she meets in her personal life that she works as a "counselor." Is this a violation of ethical conduct? Who could be hurt by this seemingly minor indiscretion? Apply the decision-making model above to this situation.

Confidentiality

A client who has just started treatment today tells you that there's something she really wants to talk to you about, but that you have to promise not to tell anyone else. How do you respond?

Mary, an outreach worker who is a member of a twelve-step recovery program, attends a meeting at which one of her clients is present. The client, who has told the program staff that she has remained drug free while in treatment, says in the NA meeting that she's

been using cocaine for the past week. Can Mary disclose this information to her fellow staff members? If you were the outreach worker, how might you handle this situation?

Sharid worked with you as a fellow outreach worker until she took a job with another agency. When she left two weeks ago, she transferred a case to you for continued services. This case involves a client named Rene with whom Sharid has developed a close relationship. You run into Sharid today and the first thing she says to you is, "How's Rene?" What do you say?

On a weekend outing with your family, you run into a client from the agency who greets you briefly and then leaves. Your family turns to you and asks, "Who was that?" How do you respond?

Self-Disclosure

Jane works as an outreach worker serving addicted women, and spends a lot of time sharing her "story" with clients. This self-disclosure could be called Jane's preferred "counseling" style. The self-disclosure includes quite a few intimate details about Jane's life experiences. One could argue about whether or not this kind of extensive self-disclosure is clinically effective, but are any ethical issues raised by this practice? Apply our three-step ethical model of decision-making to this situation.

You've been given the name of a client who called the agency about entering the women's treatment program. When you call the number that the client left, you're told that she's not there. The party on the line then asks who you are. How do you identify yourself, if at all, and what message do you leave, if any?

Dual Relationships

Today Tanya has been given the name of a new client whom she's supposed to contact about entering the treatment program in which Tanya is employed as an outreach worker. She recognizes the client's name as that of a woman who has been intimately involved with Tanya's ex-husband. Apply the three-step model of ethical decision-making to Tanya's situation. If you were Tanya, what would you do?

Margaret works as an outreach worker and sells cosmetic products on the side to make extra money. Recently Margaret has been offering these products to clients at a discount. Is this a service that clients appreciate or an ethical violation on Margaret's part? What kinds of problems, if any, could arise from this practice?

Allegations of Unethical Conduct

You're at a community reception on Saturday night talking with a cluster of nine people. When you introduce yourself and say where you work, someone next to you turns and says loudly that that must be a very interesting place to work because her neighbor, who is a client at the agency, has been describing the ongoing affair the client is having with her counselor. The lady reporting this mentions both the name of the client and the name of the counselor. You now have nine people turned to you, waiting for your response. What do you say? What actions, if any, should you take before leaving the reception? Should you—and would you—report this allegation to a supervisor at your agency? What if the allegation was about your supervisor? Would you report it to the person about

whom the allegation was made? How would you respond to casual, "How was your weekend?" inquires from other staff on Monday morning? Apply our decision-making model to this situation.

Duty to Warn/Intervene

In the course of making home visits and transporting mothers and their children, outreach workers have opportunities to observe many things that are cause for concern. Some of these situations inevitably involve a conflict between loyalty to the client and client confidentiality on one hand, and one's ethical and/or legal duty to intervene to protect the client's children on the other. Describe how you would respond to seeing the following during a home visit:

1. *An empty refrigerator*
2. *Piles and piles of dirty clothes and dirty dishes, both of which appear to be infested with many kinds of bugs.*
3. *Bruises on a client who hasn't been to treatment in three days.*
4. *Dark marks on a child that look like abrasions or burns.*
5. ____

You're making morning rounds picking up clients and taking them back to the treatment center. When you get to Martha's house, she runs out to the van and says that her babysitter hasn't arrived yet but should be there in a few minutes. As she steps into the van, Martha says, "Let's go ahead; I'm sure the kids will be fine until she gets here." How would you respond? Apply the decision-making model to this situation.

This morning in group, a client becomes very ill and starts spitting blood. You have no knowledge of this client's HIV status. Describe your response to this situation as you and several clients in the group approach her to offer assistance.

Relationship Boundaries

Many people interviewed in the preparation of this manual commented on the vulnerability of outreach workers in their relationships with clients. As one supervisor noted:

> *I think outreach is one of the most difficult roles in human service. As a therapist, you're not in the person's home and you're not required to cross those boundaries into the client's personal life. But as an outreach worker you are out there in their home and interacting with their children and their partners, and yet we do very little to help outreach workers figure out how they can maintain a zone of emotional safety for themselves while they are in such situations. We just sort of throw them out there and rely on their instincts.*

In this section we hope to provide a safe arena in which you can explore some of the boundary issues in the relationship between the outreach worker and the client. Review the list of behaviors below and place a letter before each one indicating whether you think that behavior is:

A (Always okay for an outreach worker), S (Sometimes okay for an outreach worker) or N (Never okay for an outreach worker).[1]

___ Giving a client your home phone number

___ Hugging a client

___ Kissing a client

___ Visiting a client at night

___ Inviting a client to your home

___ Keeping a homeless client in your home overnight

___ Lending personal money to a client

___ Developing a personal friendship with a current client

___ Developing a personal friendship with a former client

___ Having a sexual relationship with a current or former client

___ Helping a client clean her house

___ Transporting clients in your personal vehicle

___ Taking a client's dirty laundry home with you to wash

___ Having an intimate relationship with a family member of a current or former client

___ Accepting a gift from a client

___ Giving a gift to a client

___ Helping a client move from one apartment to another

___ Hiring a client to do work for you

___ Serving as an AA, NA, or CA sponsor for a client

___ Socializing with a client away from work

Reading Resources

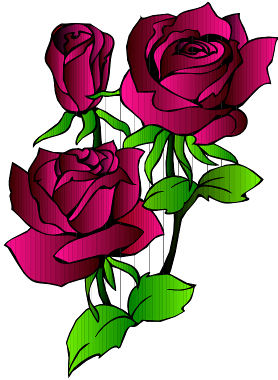
Bissell, L. And Royce, J. (1994) *Ethics for Addiction Professionals* Center City, MN: Hazelden.

Milgrom, J. (1992) *Boundaries in Professional Relationships* Minneapolis, MN: Walk-In Counseling Center.

Peterson, M. (1992) *At Personal Risk: Boundary Violations in Professional-Client Relationships* New York: W.W. Norton & Company.

[1] The design for this exercise comes from Jeanette Hofstee Milgrom's excellent manual, *Boundaries in Professional Relationships.*

White, W. (1993) *Critical Incidents: Ethical Issues in Substance Abuse Prevention and Treatment* Bloomington, IL: Lighthouse Institute.



Section 5.0
Professional Development Issues

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5.1 Time Management

Learning Objectives

1. Discuss the time constraints imposed on the treatment process by managed care and the effects of these constraints on time management for outreach workers.
2. Take an inventory of how you currently use your time.
3. Discuss time-management techniques that have been used successfully by outreach workers.
4. Discuss people-pleasing, workaholism, and procrastination, and their effects on time management.

Outreach Under Managed Care

Outreach workers who have been involved in the project since its early years have seen a drastic reduction in the number of hours women can spend in intensive outpatient treatment, down to the 75 hours now allowed by Managed Care. This puts more pressure on clients—many of whom are too wounded to do much more than get **ready** for treatment in 75 hours. It increases the danger that women will feel abandoned by a treatment system that was designed to give them the time-intensive nurturing that they need.

Because of these time limits, many of the clients' treatment and case management needs have been spilling over onto the outreach workers. In terms of skill, knowledge, and motivation, the outreach workers have no trouble handling these extra responsibilities. But in sites whose client lists are full, it adds to the time pressures in an already demanding job.

If you were an outreach worker before Managed Care, how has your job changed as the length of treatment has changed?

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____
____

What changes have you had to make in what you do in order to keep up with these changes?

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____
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Your Time-Management System

Before looking at possible ways of improving your time management system, please take a quick

inventory of your current system. If you're brand-new to outreach, fill in as much information as you can based on the information you've been given.

How many clients are on your current caseload? _________

How many clients do you see on an average day? _________

What's the highest number of clients you've had on your caseload? _________

What's the lowest number of clients you've had? _________

What are your usual working hours (start time and end time) in a day? _________

How many days a week do you work? _________

There's no such thing as a "typical" day; but if there were one, how would you describe it in terms of your time use?

Start Time	**End Time**	**Total Time**	**Name or Type of Activity**
_______	_____________	___________	____
_______	_____________	___________	____
_______	_____________	___________	____
_______	_____________	___________	____
_______	_____________	___________	____
_______	_____________	___________	____
_______	_____________	___________	____
_______	_____________	___________	____
_______	_____________	___________	____
_______	_____________	___________	____
_______	_____________	___________	____

When do you usually make phone calls? ____

When do you usually log your activities? ____

When do you usually talk to your supervisor?

____

When do you usually meet with the treatment team? ___________________________________

When do you usually do your urine drops? ____

When do you usually take your breaks? ____

If you have trouble setting priorities, who helps you with that? ___________________________

On a scale of 0 to 10, how comfortable are you with time management? ____________________

What part (or parts) of time management are still the most difficult for you?

____

____

____

Where might you go to get help for these problems?

____

____

Time Tips from Outreach Workers and Supervisors

Of all the subjects outreach workers and supervisors were interviewed about, time management was the one they had the least to say about. That might mean that time management in outreach is no problem, or it might mean that everybody's so busy they haven't had time to think about it. It's probably the latter—that people are so busy *doing* that they don't have time to examine what they do and how they might fit it in more comfortably. As one outreach worker said, "It's a hard, demanding job."

Here are a few tips from outreach workers and supervisors:

- Log your activities as you do them, or as soon after as possible. Don't count on remembering things later.
- Bill from your daily log sheets as the activities take place. Don't wait until the end of the billing period. You'll drive yourself and your supervisor nuts. It will be much less painful if you get it done a little at a time.
- Billing on a daily basis is also a good way to keep an eye on how much of your time is being used by which clients. If a particular client is taking up a high percentage of your time, you know something's wrong. It could be that either you're being manipulated, or this client needs more intensive services in another area of treatment.
- Keep notes on all the things that need to be done. Use pads that have copies, so when you write a note to someone else, you can keep a copy for follow-up. In weekly meetings, check off all the things that have been done and make plans for the ones that still need to be done.
- Keep a calendar with notes on which clients showed up, which ones didn't show up and why not, new referrals, what you've been doing, anything significant that was going on, etc. This calendar can be used by all Project SAFE staff at your site. You and the other staff can develop a code system, so you don't need much space to chart these things. It will help you with your record keeping and help other staff with charting.

- Work together with your supervisor on setting clear and effective priorities. You can help one another.
- In many areas, home visits are usually much safer in the morning than in the afternoon. Become familiar with the areas you're visiting, and schedule your visits for the safest times. Make sure you work with your supervisor on this, so everyone understands this scheduling need (see the module on "Safety Tips for Outreach Workers").
- Make your phone calls to clients early in the morning, then communicate with your supervisor and make a list of what you need to do. Then go on home visits, and/or pick up clients and get them on site in time for their sessions. While clients are in session, make your phone calls to DCFS, process your drops, and review your daily list from this morning.
- Schedule in enough break time to avoid burnout!

Which of the tips listed above seem possible for you, and seem like they might help in your time-management efforts?

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____
____

Are there any of those tips that wouldn't work for you at all? If so, why wouldn't they work?

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____
____

What time-management tips would you add to the lists above?

- ____
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____
____
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People Pleasing, Workaholism, and Procrastination

For many people, even the best time-management systems are only partly effective, because the main problem is not the amount of work or the way it's been prioritized. The problem is in their relationship with work. Of these kinds of troubles, the three most common are people pleasing, workaholism, and procrastination. Sometimes they show up together, and sometimes separately.

- *Dora is an outreach worker who can't seem to say "no" to anyone. She always seems to be making unscheduled trips for clients, and sometimes spends a lot of time with one or two particularly needy clients. Whenever her supervisor—or anyone else—asks her to take on more work, she agrees to do it, even if she has her doubts about whether or not she can handle it. If a client or a co-worker stops her in the hall at the Project SAFE site, she feels as if she has to talk to that person until that person is ready to stop talking, even if there's somewhere else Dora is supposed to be. When Dora is home, she's always doing whatever her children want, and never takes any time to do the things she's always wanted to do. She walks around feeling resentful and frustrated much of the time, but doesn't want to say anything to anyone about it, for fear that they wouldn't like her. If you haven't guessed, Dora is a people-pleaser.*
- *Demaya is the best outreach worker at her site. She has a client load of 14, she works an average of 13 hours a day, and she often works on weekends. She never takes lunch breaks, and talks to her co-workers only when it's necessary to touch base on work matters. She often does work that's supposed to be referred to other staff. When people ask her why she didn't refer the work, she says "It was easier to just do it myself. Really, I don't mind." Demaya drinks a lot of coffee and takes a lot of antacids. She spends as much time with her family as she can, but her marriage is suffering because there never seems to be enough time to work through the everyday conflicts and problems that married people have. Everyone at work tells Demaya that she's a workaholic. Her supervisor tells Demaya her that she's concerned about her work patterns, but in the next breath she praises her superior performance. Everyone at work respects her.*
- *Cindy always seems to be doing things at the last minute. She's often late on her home visit and transportation schedules. She fills out her daily activity logs late, often making up entries because she doesn't remember exactly what she did. She gets her billing done in the last few minutes of the billing period. She feels anxious and guilty every time she does something late, but she still keeps doing it that way. The more anxious and guilty she feels, the more she gets behind. Cindy ends up spending extra hours at work catching up, then resents the fact that she doesn't have enough free time. Her house is a mess. She keeps waiting for a good stretch of time when she can clean it completely, top to bottom, but that time never comes. She avoids making plans with friends so she'll have more time for work and housework, but she ends up spending a lot of time zoning out in front of the TV and eating Cheetos. She really wants to get some help for her procrastination problem, but she keeps putting it off.*

What do these three women have in common? They expect far too much of themselves. Those expectations cause quite a bit of anxiety. They react to that anxiety in different ways.

- **People-pleasers** expect to be cooperative, helpful, and likeable to everyone, all the time. They're afraid of making anyone angry or having anyone dislike them. If they disappoint someone, it feels the same as if they had hurt that person. They try to do what people want them to do, and to tell people what they want to hear. They think that they're the only ones who suffer, but the people closest to them are pretty frustrated. They can sense the people-pleasers' hidden frustration and resentment. They never know if what they're hearing is the truth, or if it's just what the people-pleasers think they want

to hear. A people-pleaser's work schedule is never definite. It's always subject to change depending on who wants what right now. It's hard for the people-pleaser to set limits and stick to them, and it's hard for the supervisor to deal with this lack of clear boundaries.

How much (if any) of the people-pleaser do you have in you? How does it come out in your work?

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____
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Hope for the people pleaser comes in practicing saying "no." It comes in learning that disappointing people is not the same as hurting them; that telling people only what they want to hear is cheating them out of the truth; and that people may like you if you compromise yourself for them, but they'll never respect you. Often the psychological roots of people pleasing run deep, and therapy is necessary before the behaviors can change in any meaningful way.

- **Workaholics** expect tremendous things of themselves—great achievements, the highest performance, and no mistakes. These expectations create quite a bit of anxiety. The only way they know to relieve that anxiety is to work longer and harder. One other thing is also relieved during their working hours: it's a way to avoid the discomfort of working through the conflicts and problems of everyday life in intimate relationships with other people. The people who try to have intimate relationships with them often feel angry, cheated, and neglected. In the case of their children, this can do some psychological damage. But their organizations and supervisors reward them for their addictive relationship with work. They may express concern for the workaholics' health, but there's always that other message: "We couldn't do it without your extra effort."

How much (if any) of the workaholic do you have in you? How does it come out in your work?

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____
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____

Hope for workaholics comes in looking honestly at their expectations of themselves and the origins of those expectations (usually in their childhood). As long as they expect far too much, the anxiety will drive them to work far too hard and too long. Workaholics also need to look at the effects of their work patterns on their relationships, and to ask themselves if the work is worth the damage it does in the rest of their lives. They need to look at the tasks of intimacy that are uncomfortable to them, and to see how much that discomfort is prompting them to use overwork to avoid those tasks. Usually therapy is a good idea. Workaholics also need to force themselves to take breaks. They need to schedule leisure time and stick to that schedule, no matter what else needs to be done. Sometimes it might help to talk to a few other workaholics who have been forced by

heart attacks, bleeding ulcers, chronic fatigue syndrome, etc to take it easy.

- Believe it or not, **procrastinators** are usually driven by the same high expectations of themselves as workaholics. They expect to do monumental things, and to drive themselves relentlessly until they're done. They make plans to do everything non-stop, and to work impossible hours without a break. Those expectations set up intense anxiety in them. Their pattern is to handle that anxiety by escaping it—by wasting time, by doing other things, by getting caught up in conversations, by goofing off, etc. The more they goof off, the higher their anxiety gets, and the more they need to escape. When the deadline gets close enough, they put in super-human effort to get everything done. They end up exhausted, expecting even more of themselves, and fearing the next deadline just as much as they did this one.

  How much (if any) of the procrastinator do you have in you? How does it come out in your work?

  ____
  ____
  ____
  ____

  Hope for procrastinators comes in realizing that they're not just basically lazy, as they'd always feared. Their problem lies in their impossible expectations of themselves. They need to look at the origins of those expectations, and to work on lowering expectations to a manageable level. They need to schedule breaks, free time, and leisure activities for themselves, so the future won't look like a prison of work that they have to try to escape. They also need to make sure not to make any commitments they can't keep.

  A good book for procrastinators is *The Now Habit* by Neil Fiore (Los Angeles: Jeremy P. Tarcher, Inc.).

In looking over these descriptions, do you see anything that you might change in your work and leisure habits? If so, what?

____
____
____
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It's a good idea to share your answers to this module with your supervisor, who might be able to help you work on some of these things. If your project has more than one outreach worker, you could even work together as a team to develop a time-management system.

5.2 Living the Message: Stress, Strain, and Strategies of Self-Care

Learning Objectives

1. Identify at least three early warning signs of personal/professional stress.
2. Recognize at least two professional situations that raise your personal vulnerability.
3. Describe at least three strategies that you can use to manage personal stress.

Stress and Burnout in Providing Outreach Services

Stress and frustration exist in many areas of human service, but outreach workers at women's treatment settings may be subject to some special types of strain. In the space below, identify at least three aspects of outreach work that cause different kinds of stress than you would experience in other human-service roles.

1. ______________________________
____
____

2. ______________________________
____
____

3. ______________________________
____
____

Early Warning Signs

In order to manage stress in the outreach worker's role, you need to be able to recognize the early warning signs of excessive stress. Each of us over a lifetime has developed unique vulnerabilities to stress, a unique style of responding to stress, and a unique pattern of early warning signs that tells us our traditional style is beginning to break down. In the space below, identify the categories of symptoms that are most typical of your **earliest** warning signs of stress:

___1. *Health*: Fatigue, colds, fever blisters, headaches, sleep problems, stomach problems, muscular pain, excessive sweating/urination, the flare-up or worsening of existing medical conditions.

___2. *Excessive Behavior*: Using more caffeine, tobacco, alcohol, or other drugs; eating more or less; becoming more irritable and/or aggressive; gambling; going on shopping sprees.

___3. *Emotional Adjustment*: Extreme mood swings, paranoia, emotional withdrawal, depression, tendency to cry, increased daydreaming, undefined fears, feeling of being trapped, guilt feelings, intolerance.

___4. *Relationships*: Isolation, over-involvement, increased conflicts with co-workers and friends, increased strain in family relationships.

___5. *Attitudes*: Boredom, cynicism, sick humor, hyper-criticism of others, negativity, feelings of hopelessness and frustration.

___6. *Other*: ____

High-Risk Situations

Outreach workers are also different one from another in the kinds of situations they find most difficult. Listed below are a number of situations that outreach workers have encountered. Place a check mark by the three that you, personally, would find most difficult to handle.

___ A prospective client fails to agree to come to treatment

___ A client relapses

___ A client delivers a drug-exposed infant

___ A client neglects/abuses her child

___ Conflict with a co-worker

___ A client stays in a destructive relationship

___ A client refuses to involve herself in AA or other appropriate Twelve-Step/support groups

___ A client's home is crawling with bugs

___ Clients argue with each other in the van

___ A client dies

___ Threats to personal safety

___ Fear of funding cuts and loss of your job

___ ____

___ ____

Replenishing Hope

Some studies have found that people in the helping professions are particularly vulnerable to burnout when they lose their sense of idealism—their belief that what they do is going to make a difference. As you learned in the module on "Realistic Expectations," focusing on the small successes in clients' lives can help you keep your sense of hope and accomplishment alive. What are some other ways you might keep your sense of hope and idealism alive?

1. ____

2. ____

3. ____

Decompression Rituals

Decompression routines are rituals that tell us and others that one part of our daily life (professional) is ending and another part (personal) is beginning. Ideally, decompression rituals take place in the 90 minutes surrounding this transition. In the space provided below answer the following questions.

1. What things do you routinely do at the very end of the day before you leave the workplace that help you bring your professional day to a close?

____

____

____

2. What things do you do between leaving your agency and entering your home that help you leave work at work and focus on your personal life?

____

____

____

3. What things do you do in the first hour after you get home that help you shed your professional role and enter your private life?

____

____

____

After reviewing the above list, answer the following statements about the activities you've named, by circling YES or NO.

YES NO 1. They help me leave work stress at work.

YES NO 2. They include some kind of physical activity.

YES NO 3. They involve me with people with whom I'm comfortable expressing strong emotions.

YES NO 4. They include things that give me a great deal of personal pleasure or satisfaction.

YES NO 5. They don't cause other problems in my life (for example, if I'm trying to keep my weight down and I need to eat a chocolate sundae every day at 6:00 in order to unwind, it probably is causing problems in my life.

Centering Rituals

Centering rituals are short time-out periods that can help us stay focused on our personal values. These are activities that we do alone that help us remember what's most important in our lives. Centering rituals can keep us from getting overwhelmed and "off course" from our primary service mission. These rituals can include prayer, moments of quiet reflection, special meditative techniques, reading particular pieces of literature, listening to inspirational songs, or going for short walks.

The centering rituals I use most frequently include: ______________________________

____

____.

Social Supports

Outreach workers can work under very high stress conditions for very long periods of time as long as they have a rich network of supports to sustain them in this work.

In the space below, list the names of at least two people in each of the following categories. Some will be easy to fill in, and others may be difficult.

1. Professional supports at work. (These are people who provide personal or technical support that helps you do your job and feel good about where you work.)

   a. ________________________ b. ________________________

2. Professional supports outside of work. (These are people who work in your field but don't work at your agency, from whom you get support and with whom you can "talk shop.")

   a. ____________________ b. ____________________

3. Mentors. (These are very special people in your profession whom you admire and who have encouraged you professionally and personally. They can be from inside or outside your current agency.)

   a. ____________________ b. ____________________

4. Family supports. (These are people in your family and intimate social network who give you support when you go home from even your worst days at work.)

   a. ____________________ b. ____________________

5. Non-work social supports. (These are people with whom you socialize regularly but who don't work at your agency. P.S.: When you're with them, you don't spend all of your time talking about work.)

   a. ____________________ b. ____________________

Look at the lists above. Which were the most difficult to fill in? Are there areas in which you need to concentrate on developing new supportive relationships?

Acts of Self-Care

In a service profession, it's sometimes hard to step back and focus on our own unmet needs. We see people whose needs are so many and so intense that we can even feel guilty for focusing time on our own needs, interests, and pleasures. But long-term effectiveness as a service provider requires that we replenish ourselves physically and emotionally—that we find ways to recapture our own pleasure in living. You can do this through simple acts of self-reward, experiences that remind you that your own needs are legitimate and worthy of your time and resources. In the space below, list five things that you can do in the next month as acts of self-care.

1. ____
2. ____
3. ____
4. ____
5. ____

Acts of Service

It might seem strange that people whose professional work is to provide services to others can

find acts of service in their personal lives replenishing. But that's what interviews with some of our outreach workers in Illinois suggests. Several outreach workers said that service activities in their personal lives helped reinforce the fact that their work as outreach workers is much more than a job. They saw private acts of charity and service as a way to remind themselves why they were drawn to outreach in the first place. They also emphasized that it was important that the type of the service be different from the work that they did in their jobs. Acts of service can include things like volunteering for a community agency, service activities through your church, offering assistance to a stranger in need, or simply helping a friend or neighbor. Is there a kind of service activity that you're interested in but you've never pursued? If so, list it below.

Area of Service Interest ____

____

How might you pursue this interest?____

____

____

Advice from other Outreach Workers

In preparing this curriculum, we asked several outreach workers to comment on the stress they experienced in their jobs and how they handled it. Here are some of the things they said:

> *It's easy to get caught up in all kinds of unrealistic expectations working with these women, and then you find yourself getting overwhelmed and asking, "Are we making any difference?" What I've learned is that you have to stay focused on the potential for hope. You have to define your work in terms of small successes that can add up to big successes. I have a woman who just delivered a drug-free, healthy baby and all I could think of was, "We made a difference with this one!"*
>
> *My stress lowered when I figured out that these clients were not my kids—that they had to learn things on their own. It was then that I could stop taking too much responsibility for what they did or didn't do. I'm not superwoman. I can't cure anybody—I can only support them and be there for them while they cure themselves. It took me quite a while to figure this out. I stopped trying to be perfect and started trying to just consistently be there for them.*
>
> *I do two things. First, in the morning, I try to focus on nothing but my son. I don't think of anything related to work until he leaves for school. That focus reminds me what's most important in my day. Then at the end of the day, we have about thirty minutes after we've dropped the clients off before we get off work. The other outreach worker and I use that time as a winding-down period. We talk about what happened in our day—what was good and what was most difficult. That helps me leave stuff at work and not carry it home with me.*
>
> *For me, it's my relationship with God. I think it's important for an outreach worker to have a spiritually based life. Outreach is hard and you have to have some type of*

relationship for yourself. In order to give what we give to our women, you have to have something to give away. If you're not being spiritually fed, it's hard.

For me, I need to make meetings. I can't give away what I'm not doing. I can't tell them they need to make meetings if I'm not going to meetings. It is also important for me to separate who I am as a recovering person and who I am as an outreach worker and to keep this distinction clear in my relationships with the women. There are times I step out of my professional role and talk to them addict-to-addict, and other times I let them know I'm giving them a professional recommendation. Keeping the roles straight is important for me and for them.

My major source of support is the other outreach worker I work with. We encourage each other and, when we need to, confront each other. To keep doing this work for any length of time, you have to have that base of support within the staff.

You've gotta take time out. I just gotta get away sometimes for rest and perspective. And I got a counselor myself. Oh, God, that killed me! That hurt my pride, but I had to do it. That's what helped me hang in so long.

You've got to be willing to give a little, take a little, close your eyes a little, bend a little.

It's okay to burn out as long as you don't make an ash of yourself!

Personal Action Plan

This training is designed to give you an opportunity for professional and personal self-reflection. Review the items below and place a check-mark beside the steps you need to take in order to improve your ability to manage personal and professional stress:

___ I need to see a physician for a thorough physical check-up or to get active treatment for conditions I've been ignoring.

___ I need to improve my diet by choosing healthier foods and taking in less cholesterol, fats, sugar, and salt.

___ I need to establish and stick to a regular program of exercise.

___ There are toxic habits, such as smoking, that I need to eliminate from my life.

___ I need to learn some specific techniques to help me manage particularly stressful events.

___ I need to set more effective limits on myself and reduce my commitments.

___ I need to learn how to express my frustration more effectively, and not keep it bottled up.

___ I need to develop new supportive relationships.

___ I need to develop better decompression rituals to keep my work-related stress from spilling over into my personal life.

___ I need to develop a few centering rituals to help me stay focused through each workday.

___ I need to spend more time cultivating leisure-time enjoyments.

Review the items above that you checked. Is there one to which you are ready to commit yourself to action? If so, fill in the following statement.

IN THE NEXT MONTH, I WILL ____

____

Reading Resources

Davis, M. Eshelman. E. And McKay, M. (1989). *The Relaxation and Stress Reduction Workbook*. Oakland, CA: New Harbinger Publications.

Freudenberger, H. (1980). *Burnout.* Garden City, New Jersey: Anchor Press.

Pelletier, K. .(1977) *Mind as Healer, Mind as Slayer: A Holistic Approach to Preventing Stress Disorders.* New York: Delta Publishing.

White, W. (1986) *Incest in the Organizational Family: The Ecology of Burnout in Closed Systems* Bloomington, IL: Lighthouse Institute.

5.3 Career Mobility

Learning Objectives

1. Discuss the value of the outreach worker's role—to the client, to Project SAFE, and to the treatment field as a whole.
2. Discuss other outreach workers' ideas and observations on possible career paths.
3. Identify your own career goals and the steps that would be necessary in order to achieve them.

The Outreach Worker's Role

It's interesting to look at how the outreach worker's role is valued, and how that value is expressed. It's not a very highly paid role, because it's an entry-level job that doesn't require much education, training, or work experience. Still, it's a role that most people—education or no education—couldn't fill. It takes a combination of inner qualities that most people don't have and couldn't get through training, education, or work experience.

Outreach is also a role that has profound impact on many lives—the lives of clients and of their children. Clients have said, in no uncertain terms, that if it weren't for their outreach workers they wouldn't have entered or stayed in treatment. Given the Project SAFE client population, this would in many cases mean death, the loss of their children, or further child abuse or neglect.

The importance of your role to the treatment field is also clear. The overall client population shows ever-greater numbers of dually diagnosed patients, earlier onset of substance abuse and addiction, and lower levels of functioning among clients.

Developing generations of addicts are being subjected to even worse abuse, neglect, and exposure to violence than were their predecessors who are now in treatment. "Take-it-or-leave-it" treatment won't work when these generations are ready to hit bottom. Society will have to pay the relatively low cost of the kind of outreach you're pioneering, or pay a much higher cost in rampant crime, violence, prison accommodations, public health emergencies, and the placement of countless abused and neglected children.

What trends do you see in your work, and how do you think they'll affect the future of treatment?

____
____
____
____

How do you think the outreach role could be taken into other parts of the field?

People in Project SAFE have talked about "professionalizing" the outreach worker's role. This would include giving outreach workers more training and education benefits, increasing salary scales, and creating career paths through agencies. What would that mean to you?

Possible Career Paths

Many outreach workers who were interviewed said they liked the work they were doing. "I'm happy where I'm at," said one. "I've thought about . . . being a therapist. It's not what I want." About the outreach role, she said, "I like that freedom. I like going out and meeting these women and working with them and sharing what I know. There is just so much involved."

Others stressed the importance of getting more education and training in the outreach role. "You can never learn too much. And whatever you learn today is obsolete. You need to continue to grow," said one woman. Another mentioned the importance of continuing her own education as an inspiration for her clients. Continuing education, workshops, seminars, training, and certification are all important options.

One outreach worker suggested a career path within the outreach role. "I think that an average worker who has been in the field in a growing agency should be able to move up to the position of senior outreach worker and supervise the other outreach workers. That's one way that the special qualities of outreach will not be lost. A lot of times outreach workers are living by the seat of their pants. [They need] someone who's been in the field and knows all the pitfalls, to be able to guide them."

According to some of the people interviewed, the most common career path—with the appropriate education—is from outreach worker, to case manager, to counselor to supervisor. Others mentioned upward moves into other areas of the field, like DUI programs, inpatient treatment, or rehabilitation. But some people interviewed seemed to have no clear sense of career mobility within the field.

When you picture yourself five years from now, what would you like your career to be?

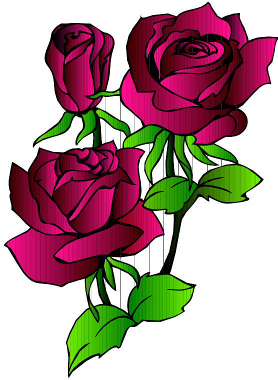
If you want to do that in five years, what will you need to do to get ready for it?

What resources (people, materials, schools, talents, inner strengths, etc.) will you need to call on in order to do those things?

What do you think are your greatest assets as an outreach worker, and as a human being?

What other qualities do you most want to develop in yourself, as a person and as an employee?

See the module on "Learning About Addiction and Recovery" for more information about professional development.



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A Developmental Model of Recovery *

By William White, in collaboration with Maya Hennessey,
Deborah Oberg and Diane Sonneville

While the original Project SAFE program manual published in 1988 raised a number of theoretical questions about the nature of addiction and recovery in women, there was insufficient data to fuel substantial theory-building. The Project SAFE experience is now long enough and rich enough to begin this process. The 1988 Program Manual, in calling for research to elucidate a developmental model of recovery for women involved with Project SAFE, noted that the appropriateness and timeliness of our service interventions hinged on knowledge in this critical area. In the continued absence of data that could be provided through long term outcome studies of women involved in Project SAFE, Project evaluators solicited stories and perceptions about stages in the recovery process for SAFE women from DCFS workers, outreach workers and treatment staff at all of the SAFE sites. An attempt was then made to organize this anecdotal material into a beginning conceptualization of the developmental stages shared by the majority of women in this project. This brief paper represents the first attempt to provide a theoretical framework from which recovery of Project SAFE women can be understood and from which interventions can be strategically selected and appropriately timed.

Recovery as a Developmental Process

There are a number of key propositions central to a developmental model of addiction recovery. Those most crucial to organizing the experience of women in Project SAFE include the following:

- Addiction recovery, like the active process of addiction, is often characterized by predictable stages and milestones.
- The movement through the stages of recovery is a time dependent process.
- Within each stage of recovery are developmental tasks—skills to be mastered, certain perspectives to be developed, certain issues to be addressed—before movement to the next stage can occur.
- The nature of the developmental stages of recovery are shaped by the characteristics of the addict; the nature, intensity and duration of drug use; and the social milieu within recovery must occur.
- Developmental stages of recovery, while highly similar within subpopulations of addicts, may differ widely from subpopulation to subpopulation.
- Treatment interventions must be strategically selected to resolve key issues and achieve mastery over key developmental tasks inherent within each individual's current stage of recovery.

** This document first appeared as a resource paper included within the 1990 Project SAFE Program Handbook authored by William L. White, M.A. and published by the Illinois Department of Alcoholism and Substance Abuse (now the Office of Alcoholism and Substance Abuse-Illinois Department of Human Services) and the Illinois Department of Children and Family Services. The the entire Project SAFE report may be obtained by contacting either of these two agencies.*

- Treatment interventions appropriate to one stage of recovery may be ineffective or pose iatrogenic risks when utilized in another stage of recovery.

What follows is not a developmental model of recovery for women. The proposal of such a model would imply with arrogant oversimplification that substance abusing women constitute an homogenous group who present with gender-defined and gender- shared problems that are unaltered by other dimensions of individual character and experience. Such a model would also imply that there is a shared developmental trajectory (a singular pathway) of recovery for all women and that there exists a narrowly proscribed treatment technology to provide guidance through this developmental process. What follows is a developmental model of recovery for *persons* who share certain experiences and characteristics. There are many women for whom this model would not apply and many men for whom it would. The fact that more women than men share the core characteristics defined below is a function not of gender biology but the social, economic and political oppression within which women are born and within which they must seek their destiny.

The Core of Shared Experiences and Adaptations

The developmental trajectory of addiction recovery is shaped by the totality of experiences each addict brings to treatment. Populations for whom similar life experiences have shaped core characteristics of personality share similar developmental processes of recovery. Project SAFE women were human elements in a complex web of interlocking relationships (and problems) spanning several generations. The women who entered Project SAFE over the past four years shared many experiences that shaped their perceptions of self, the self-drug relationship and the self-world relationship. It is impossible to understand the nature of addiction and recovery in these women without understanding the core characteristics which have been shaped by these experiences. It is our judgement that the core experiences most crucial to the developmental stages of recovery in SAFE women include the following:

- Early and continuing losses
- Parental pathology: High incidence of parental addiction and/or psychiatric illness
- Physical and sexual abuse
- Predatory social environments
- Recapitulation of family trauma in adult relationships

When clinicians within Project SAFE compared the experience of SAFE women with non-addicted women they had counseled who had not been involved in abuse or neglect of their children, significant differences emerged. Women from both groups reported sexual abuse in childhood, but Project SAFE women reported early age of onset of sexual abuse, a pattern of multiple rather than single perpetrators, a pattern of sustained (often measured in years) rather than single event abuse, and the presence of violence or the threat of violence as part of the pattern of abuse. What distinguishes Project SAFE women is not the fact of physical or sexual abuse or early childhood losses in their lives—events that many women may experience—but the severity of the physical and emotional trauma resulting from the intensity and duration of these experiences.

What Project SAFE clients tended to share was not only these conditions and events in their lives, but also, and perhaps more clinically significant, were the meanings which they attached to these experiences. The experiences catalogued above drove home deeply internalized messages about

oneself and the nature of the outside world. Some of these internalized messages become mottos for living. The nature and intensity of these mottos will influence the outcome of each client's involvement with addiction and with recovery.

- I am unlovable; I am bad.
- There is no physical or psychological safety.
- If I get close to people, they will die or leave me.
- My body does not belong to me.
- I am not worthy of recovery.
- Everybody's on the make; no one can be trusted.

Dependency as the Core Developmental Dimension for SAFE Women

In clinical staffings of Project SAFE women, the words "dependency, passivity, learned helplessness and learned hopelessness" were frequent refrains. It is our belief that shifts in this dependency dimension mark the essence of the developmental process of recovery for SAFE women.

Within our patriarchal culture, there is a deep paradox related to dependency. The culture highly values self-reliance and autonomy but prescribes roles to women which inhibit self-assertion and encourage service and sacrifice to others. Women who most inculcate those values ascribed to women are branded as "pathologically dependent." Women who challenge these values through self-assertion may be accused of somehow hurting their men, their children, their communities and their society. Acts of self-assertion may be viewed as acts of aggression, disloyalty and betrayal. While most women experience some aspects of this cultural double-bind, some women experience an intensified version of this self-dwarfing process due to generation-spanning problems in their families of origin. For the majority of women in Project SAFE, these family of origin experiences began what would become an escalating pattern of self-defeating dependency upon people and things outside the self.

Self-defeating patterns of dependency involve the following elements:

- An inability to state one's own wishes, needs, or ideas due to fear of conflict or rejection.
- A diminished capacity to define or assert one's own values and beliefs—to be self-directed.
- A severely diminished experience of self-legitimacy and self-value.
- An inability to pursue self-fulfilling, self-nurturing activities without fear and guilt.
- Achievement of esteem through identification with a person, group, or institution.
- A fear that life success or self accomplishment will be followed by punishment or abandonment.
- An inability to initiate action to resolve one's own problems.
- A programmed preference for passivity, withdrawal and helplessness when confronted by problems and challenges.

We do not view such dependency patterns as inherent in the biology or character of women. We view such patterns as flowing from self-obliterating family and cultural systems. They are survival adaptations. They are strategies of self-protection. They are defenses against physical and psychological assault. These self-defeating patterns of dependency are highly adaptive. Passivity can serve as a protective device as an alternative to challenge and confrontation with family or

cultural rules. Passivity and dependence often serve as homeostatic mechanisms within a marital/family system. Ego-sacrificing acts become ego-bolstering to others whether the other is in the role of parent, husband/paramour or therapist.

This dependency dimension influences the manner in which these women must be engaged in the change process (outreach and early treatment). Interventions that heighten guilt and inadequacy are misguided and harmful. The dependency dimension influences the changing role of the program (on-going treatment and aftercare) in the long-term recovery process. In the developmental stages outlined below, we have charted a progression from self-defeating dependence to healthy inter-dependence. The desirable and achievable goal of the change process extols not autonomy and self-reliance but reciprocity and mutuality. The process is depicted as a movement from the denial and abuse of self to an affirmation of self within the context of mutually respectful relationships—intimate relationships, family relationships and social relationships.

The Limitations of Stage Theory

In 1969, Elizabeth Kubler-Ross published her now classic work *On Death and Dying* in which she described five stages of grief and mourning (Denial, anger, bargaining, depression and acceptance). For the years that followed, many counselors have used this theoretical framework to assist them in working with grieving clients. Used appropriately, this theoretical model has helped many clinicians both understand and mediate the healing process involved in traumatic loss. Applied to restrictively, this theoretical model has been misapplied by some clinicians to program the grief experience of clients for whom alternative styles of healing may be more naturally appropriate. Models—as metaphors of collective experience—can be tools of empowerment for both clinicians and clients, particularly when the model fully embraces the experiences and needs of the particular client. When a model doesn't fit the experience and needs of the client, its application results in unsuccessful treatment or harmful treatment.

The construction of a developmental model of recovery for women in Project SAFE is an important milestone in the evolution of this project. It provides the theoretical foundation for what works and doesn't work in our interventions with these women and their families. It provides the framework that vindicates our movement outside the traditional boundaries of substance abuse theory and technique to meet the needs of these special women. The developmental model of recovery which follows should, however, not be viewed as a road map of recovery for all women nor should the stages outlined be utilized as a prescriptive recipe whose ingredients and preparation procedures must always be the same. Our model is a road map that has utility only when it precisely reflects the clinical terrain within which we are working. When this terrain changes via core characteristics and experiences of women in Project SAFE, then the model should be adapted or discarded.

In our observation of and involvement with Project SAFE women over the past ten years, we have seen six identifiable stages in the movement from addiction to stable recovery. These stages and the role helping professionals can play in each stage are described briefly below. The stages are a composite of what we have seen with Project SAFE women. Some women skipped certain stages. Others varied the sequence. Still others went through several cycles of these stages during their SAFE tenure. The stages overlap and there are not always clear points of demarcation separating one from the other. Early stage issues such as safety and trust don't completely dissipate; there on-going management simply requires less emotional effort—the ever-present roar of "don't trust"

subsides to a whisper.

Stage 1: Toxic Dependencies

If there is any phrase that captures the pre-treatment status of Project SAFE women, it is "toxic dependencies." They bring dependencies on cocaine, alcohol and other psychoactive drugs which have interfered with many areas of life functioning. They exhibit a propensity to involve themselves in toxic relationships with abusive men and women. They also exhibit a propensity to involve themselves with social institutions, not to break these dependencies, but to sustain them over time. The Project SAFE client has little sense of self outside these dependent relationships with chemicals, people and institutions. The themes of death, loss, abandonment, and violation of trust in her life are constants that progressively diminish self-respect and self-esteem. Whether manipulated through nurturing or through violence, she has learned that the world is a predatory jungle in which physical and psychological safety is never assured. Out of self-protection, a secret self is created and encapsulated deep within this women. She protects and hides this self from exposure to outsiders; her true self can never be rejected because it will never be revealed. Sealed in fear and anger this secret self becomes so deeply hidden that the woman herself loses conscious awareness of its existence.

Locus of control during active addiction is increasingly of external origin. Her relationship with drugs cannot be internally controlled by acts of will or resolution. Her relationships with others are marked by inconsistency and unpredictability of contact. Everything in her life seems to be shaped by outside forces and persons. By the time a woman comes in contact with Project SAFE, the power to shape her own destiny has been obliterated by the chaos of her life. Her life is buffeted by the conflicting forces of her drugs, her drug using peers, her family, her intimate partner, and a growing number of social institutions closing in on her lifestyle. Amidst this backdrop of chaos, she slides into increased passivity, increased hopelessness and helplessness and increased dependence on drugs and toxic relationships. There is pain in great abundance but insufficient hope to fuel sustained self-assertion into recovery. "Powerlessness" for this woman is a fact of life, not a clinical breakthrough. The spark that can ignite the recovery process must come from without, not within. For social agencies to wait for this woman to "hit bottom" in the belief that increased pain will motivate change is delusional and criminal. Where internal locus of control has been destroyed, the client can "live on the bottom" having lost everything short of her own life and still not reach out for recovery. It is not a shortage of pain, but a shortage of hope and a lost capacity to act that serve as the major obstacles to change. More potential sources of external control eventually emerge through crises related to homelessness, acute medical problems, arrest, victimization by violence, or through the abuse and/or neglect of children.

Family of origin relationships are quite strained for SAFE women. Family members either share the client's lifestyle or have disengaged out of discomfort with the client's drug use and lifestyle. And yet family members may be pulled back in during episodes of crisis to take rescuing action on behalf of the client. The social worlds vary for SAFE women. Some are socially isolated, enmeshed in a solitary world of drug use surrounded only by a few primary relationships with active users or persons who support, via enabling, there continued drug use. Other SAFE women are deeply enmeshed in a culture of addiction—an exciting world of people, places and activities all of which reinforce sustained drug use. The drug and the roles and relationships in the culture of addiction all held out the promise of pleasure and power but alas—as a metaphor for her life—brought betrayal in

the form of pain and loss.

The etiology of the neglectful/abusive behavior exhibited by the SAFE client toward her children springs from multiple sources: the emotional deficits and debilities resulting from her own family of origin experiences, the lack of appropriate parenting skills, environmental chaos that competes with parenting responsibilities, increased loss of control over the drug relationship, and sustained exposure to a predatory drug culture. She constitutes the ultimate paradox of motherhood. Scorned and shamed by those who don't know her ("How could a mother neglect her child because of a drug?"), her desire to remain the mother of her children will remain the primary external force to sustain her through the change process.

In short, the woman who will come in contact with Project SAFE is compulsively involved in dependent relationships with abusable substances and abusing people, lives in environments that are chaotic and traumatizing, and is constitutionally incapable of a self-initiated, spontaneous break in this dependent lifestyle. All her experiences have confirmed that the world is a physically and psychologically dangerous place. Her contacts with helping professionals during this stage are likely to be marked by passive compliance (role playing) or by open disdain and distrust. There is, however, as much strength in this profile as pathology. The ultimate pathology is the environmental pathology which demanded that SAFE women sacrifice their esteem and identity as an act of survival. While the consequences of these adaptations may appear as pathological personality traits to those unfamiliar with such traumatizing environments, seen from another perspective, these are stories of survival and incredible resiliency. The strength inherent in sheer survival is the seed from which the recovery process will eventually sprout. That seed must be acknowledged, nurtured and channeled into the change process.

Stage 2: Institutional Dependency

The initiation of sobriety and the period of early recovery for SAFE women is marked by decreasing dependence upon drugs and abusing relationships and an increasing dependence upon Project SAFE staff and the institution within which it is nested. Stage 2 is marked by the following three phases: 1) testing and engagement, 2) stabilization, and 3) reparenting.

Rarely if ever do Project SAFE women present with a high level of motivation for change. The earliest stage of engagement is usually induced by external fiat (court mandated treatment or fear of losing children) or through the persistence of an outreach worker. Whether presenting with superficial compliance or open hostility, the engagement period is a ballet of approach-avoidance and ambivalence. The tipping of the scales are often shaped by the relative interactions of hope and pain. There is a hope-pain synergism (illustrated below) that dictates the outcome of our efforts at engagement.

The Hope-Pain Matrix

		HP-LH most typical initial pattern encountered with SAFE

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

Where there is high pain and high hope—a rarity—engagement can be quick and intense. Where there is low pain and low hope, there is minimal chance of treatment initiation. It is in the combinations of high pain and low hope and high hope and low pain, that the intervention technology of outreach can work its magic of persistence and consistent positive regard to alter the equation to get treatment engagement.(See Chapter Six for a discussion of this technology)

The earliest relationship between SAFE women and the treatment milieu is one of great ambivalence. Clients maintain a foot in both worlds (addiction and treatment) gingerly testing each step forward and backward. In this transition period can be found enormous incongruities and contradictions, e.g., clients who want to keep using drugs AND keep coming to treatment, clients who want staff to go away because staff make them feel good and hopeful. While this ambivalence may have its subtleties, it is most often played out behaviorally in dramatic fashion, e.g., missed days of treatment attendance, splitting in anger and then calling to seek reconciliation, relapse behavior, etc. True emotional engagement is rarely a bolt of lighting event. It is much more likely to be a slow process of engagement with every stage marked by testing behaviors.

The earliest experiences of positive regard and hope experienced by Project SAFE women can trigger strong counter reactions. The woman who too quickly reveals her secret self may react in anger (temper tantrums) or in flight (missed meetings). The hope-instilling positive regard from SAFE staff may escalate a client's self-defeating patterns of living, e.g., setting others up to reject her as a confirmation of her life positions that trust is foolish and nowhere is safe. When staff refuse to be driven back by these exaggerated defense structures, the client is forced to experience herself differently and to rethink her beliefs about herself and the world. This testing, experiencing acceptance and rethinking process may go on in its most intense forms for weeks before a woman fully commits herself to the SAFE program. For women who get through this initial stage, testing may resurface later during critical developmental milestones in the recovery process. For women who cannot resolve this trust/safety issue, there drug using lifestyle will continue unabated.

In the stability phase, outreach and case management services provided through project SAFE have

reduced the environmental chaos (housing, transportation, legal threats, etc.) to manageable levels and overall treatment efforts have created an initial (but still fragile) emotional bond between the client and the treatment team. As external threats to safety and survival subside, the Project SAFE client begins to master the personal and social etiquette of SAFE participation, e.g., regular attendance, group participation, etc. As soon as sobriety and environmental stability begins, emotional thawing and volatility escalates.

This can be a stage of raw catharsis. Pent-up experiences unleash powerful emotions when first aired to the outside world through storytelling. With the experience of safety, clients can begin peeling away and revealing layers of the secret self only to discover dimensions that were unknown even to themselves. Healing of this pain will occur in levels through all of the stages described in this model. At Stage 2, the most crucial dimension is the experience of acceptance by others following self-disclosure. There is at this stage a sense that shared pain is diminished pain—that secrets exposed to the light of disclosure lose their power to haunt and control.

There are several dimensions of reparenting within Project SAFE spread over the developmental stages of recovery outline here. At the this early stage, Project SAFE takes over a parental role with project clients, tending to issues of survival and safety. It is a nurturing, "doing for" process. At an emotional level it involves experiencing unconditional "thereness"—the consistent physical and emotional presence of the program in the life of the client. It involves the experience of consistency, a non-voyeuristic and non-judgmental openness to their life stories, and the ability to tolerate testing but still set limits. It is the experience that one can mess up but not jeopardize one's status as a family (SAFE) member. As clients become more receptive to this emotional nurturing, they may regress and become quite dependent upon the program. This escalating dependence should be seen not in terms of pathology but in terms of a developmental process of healing. It is through this increased dependence and the needs that are being met through it that the client begins to fully disengage from active involvement in the culture of addiction. The program must now meet all those needs which the client formally met within the society of addicts. The program must be available to fully fill this vacuum at this stage if contact with the culture of addiction is to be broken. Does that mean that a stage of "doing for" the client—a stage of consciously cultivating client dependence upon the treatment institution—is clinically warranted? YES!

Key developmental tasks that must be mastered by the client during Stage 2 include:

- resolving environmental obstacles to recovery.
- working through ability to maintain daily sobriety.
- relationship building with staff that transcends stereotyped role behaviors of "client" and "professional helper" (movement beyond compliance).
- learning etiquette of program participation
- breaking contact and asserting isolation from culture of addiction
- exploring limits of safety in the treatment environment via storytelling and boundary testing.
- accepting nurturing from project staff
- verbalizing, rather than acting out, compulsions of fight or flight

During Stage 2 clients still have little sense of personal identity. Where identity in Stage 1 came through identification with a drug, a drug culture, and a small number of highly abusive

relationships; identity in Stage 2 comes through drug abstinence, identification with a treatment culture, and a small number of highly nurturing relationships. Denial dissipates during Stage 2 and personalized talk about alcoholism/addiction reflects the growing recognition of "addict" as an element of identity. Clients still need external sources of control over their behavior, although these sources begin shifting from negative (judicial coercion) to positive (regard for relationships with staff).

Clients who get stuck in Stage 2 (and programs which conceive of Stage 2 as the terminal stage of treatment) contribute to the growing population of chronically relapsing clients who failing to function either in the culture of addiction or in the society at large become institutionalized clients in the substance abuse treatment system.

Stage 2 begins the reconstruction of the relationships between the SAFE mother and her children. With the resolution of environmental chaos, the initiation of sobriety, and early engagement in treatment, the most dysfunctional aspects (neglect and abuse) of the parent-child relationship have been addressed, but it may be some time before quality parenting will appear. Early recovery parenting efforts often reflect a lack of basic parenting skills and efforts to compensate for guilt related to past drug-related deficiencies in parental effectiveness,e.g, overprotection or overindulgence. As the mother herself experiences reparenting in relationships with staff, she becomes more empowered to mirror these experiences with her children, e.g., feedback, nurturing, boundary setting, problem solving, etc.

Stage 3: Sisterhood

In Stage 3, relationships of mutual respect and trust established between the client and the Project SAFE staff begin to be extended to encompass other women clients in the SAFE project—one's treatment peers. The earliest efforts in these peer to peer relationships are marked by diminished capacity for empathy, the inability to listen to another with the roar of one's own ego in check, the lack of social etiquette, and the need to clearly proscribe the limits of trust. Clients speak at the same time, fail to respond emphatically to painful self-disclosure, make commitments to each other that are broken, react to feedback with verbal attack or threats of violence or flight, etc. It is the treatment milieu that must provide the skill development and the relationship building processes to weld these disparate individuals into a mutually supportive group. Over time, clients begin to extend their trust and dependence upon staff to a growing reliance on the help and support of their treatment peers. Within the structure of the treatment milieu, they move from the position of "none can be trusted" to a realistic checking of who can be trusted and the limits of that trust. The early friendships between treatment peers constitutes the embryo of what will later be a more fully developed culture of recovery. As skills increase, the client learns to not only to speak, but to listen; to not only receive feedback, but to offer feedback; to not only receive support, but to give support. It is crucial that treatment staff provide permission and encouragement for decreased dependence on staff and increased dependence on other health-enhancing relationships within and beyond the treatment milieu.

The peer milieu is an important vehicle through which Project SAFE women wrestle with some of their most troublesome treatment issues. This is the milieu within which sexual abuse and other family of origin pain is explored. It is here that they can grieve their many losses. This is the arena within which abusive adult relationships are mutually confronted. This is the arena in which clients

come together collectively to fight back against shame and stigma to restore their honor and self-respect both as women and as mothers.

During this stage, there is an intense exploration of victimization issues. Stories of victimization are shared. Catharsis of pain and anger is achieved. A "sisterhood of experience" is achieved. Early identity reconstruction focuses on victimization issues. Individual and collective identity focuses heavily on what has been done to them. Projection is the dominant defense mechanism. One is where one is because of persons, institutions (including DCFS) and circumstances over which the client had no control. It will be some time before this focus can shift to her responsibilities, her choices, her role in her current life position.

Key developmental tasks that must be mastered during Stage 3 include:

- Extension of self-disclosure to treatment staff to treatment peers.
- Early relationships with recovering role models encountered within the treatment site.
- Exploration of victimization issues.
- Rapid expansion of social skills (parallels period of early adolescent development)
- Treatment agency focused lifestyle develops as alternative to culture of addiction.
- Shift in relationships from drug-oriented to recovery-oriented.

Stage 3 is the first time SAFE clients begin to experience themselves as part of a broader community of recovering women. Identity and esteem are increasingly based on identification with this community. The shift in identity from "addict" to "recovering addict" marks a beginning stage in the reclamation of the self. These shifts in identity are not without their risks as we shall see in the next Stage.

Major risks of relapse during Stage 3 come from panic secondary to emotional self-disclosure, relationship problems between treatment peers, and failure to sever or reframe past drug-oriented intimate and social relationships.

Stage 4: Selfhood and Self-help

Where Stage 3 focused on shared experiences, SAFE clients in Stage 4 begin some differentiation from the treatment group. There is more focus on personal as opposed to collective experience. The "victim" identity diminishes during this stage and there is a greater focus on self-responsibility. This stage involves an exploration and expiation of emotion surrounding one's own "sins" of commission or omission. Treatment time shifts from what "they" did to what "I" did. There is a confessional quality to early work in this stage with self-forgiveness being a critical milestone. There is for the first time a shift in focus from personal problems to personal aspirations. This stage marks the beginning reconstruction of self that will continue throughout the lifelong recovery process.

In Stage 4, Project SAFE women begin to experiment with the development of health-enhancing relationships outside the treatment milieu. Having developed some sense of safety and identity within the treatment milieu, they seek to extend this to the outside world by finding networks of

long-term support. The two most frequent structures utilized by Project SAFE clients for such support in Stage 4 are self-help groups and the church. This is a critical stage through which emotional support the SAFE client has received from treatment staff and treatment peers is extended for the first time to a broader community beyond the treatment site. There is also a focus on rebuilding strained or ruptured family relationships during this period. With sustained sobriety and program involvement and obvious changes in her lifestyle, estranged family members once again open themselves to reinvolvement with SAFE clients.

Self continues to be defined in Stage 4 through external relationships. A period, perhaps even a sustained period, of extreme dependence upon this support structure, while criticized by persons not knowledgeable about the developmental stages of recovery, can be the critical stage in the movement towards long-term recovery. During this period, the client's whole social world may be shaped within the self-help or religious world. This period constitutes a period of decompression from the toxicity of the culture of addiction and a period of incubation within which the self and self-world relationship are reconstructed.

If the shift in dependence from the treatment milieu to outside supports is made too quickly, the client will experience this encouragement for outside relationships as abandonment by the treatment staff. Traditional short-term treatment models that encourage this shift at a very early stage in recovery may inadvertently recapitulate the client's fear and experience of loss and abandonment. In Project SAFE we found that these relationships needed to supplement, rather than replace, those primary relationships of support within the treatment milieu.

There is a reassessment and a decision point during Stages 3 and 4 as to whether to move forward in the recovery process or to retreat back into the world of addiction. During these stages, the full implications of the recovery lifestyle become clear. There is fear that long term recovery is still not a possibility. There is fear of the future unknown and their ability to handle it. As bad as the past is, it continues to exert its seductive call as a world they know better than any other. If treatment contact and support is prematurely ended during this stage, relapse is likely.

Stage 5: Community Building

In Stage 5, SAFE women extend their system of supports into the broader community. It is at this stage that clients must figure out how to maintain sobriety while fully living in the world. It is a stage of lifestyle reconstruction. Friendships that are based neither on active addiction nor shared recovery are explored and developed. The earliest activities within this stage may begin very early or very late in the recovery process. For SAFE women, the earliest activities are often initiated via outreach workers. Tours of community institutions, getting a library card, going on picnics, bargain hunting at garage sales and flea markets, and experimenting with drug-free leisure may all be aspects of community building initiated through the treatment experience. A major aspect of Stage 5 is the establishment of drug free havens and drug free relationships that can nurture long-term recovery. Another aspect of this stage is the repositioning of the family in the community—re-establishing old healthy linkages to community institutions and building new linkages.

It is important that treatment staff possess a sensitivity to non-traditional pathways to recovery. Many recovering women may set the roots of their recovery in institutions other than traditional self-help groups. The church served as a primary support institution to many SAFE women, either as an adjunct or an alternative to traditional addiction self-help groups.

The parenting of SAFE mothers changes in a number of ways during these later stages of recovery. Earlier stages set the groundwork through the acquisition of basic parenting skills and working through stages of overindulgence and overprotection. The emotional needs of the mother are so intense early in the recovery process, it is very difficult for her to maintain a sustained focus on the needs of her children. In Stage 5, however, the intensity of these internal needs have been addressed to allow for a much richer quality in the relationship between the client and her children. Where she achieved consistent physical presence in earlier stages of recovery, she now creates a consistent emotional presence in the life of her children.

There is also a shift in Stage 5 in the relative health of the client's intimate relationships. Abusive relationships which may continue into early stages of recovery have now been changed or severed. Some at this stage will have gone through experimentation with a variety of relationships, some will have found a primary long-term relationships, while others may find themselves content for the time being to seek their destiny without the security or burden of a primary relationship.

Stage 6: Interdependence

Stage 6 in the developmental progression of recovery for SAFE women constituted not a fixed point of achievement but entry into a lifelong process of doubt, struggle, and growth. The shift from the earliest stages is one from self-negating dependence to self-affirming inter-dependence. This stage is marked by the emergence and continued evolution of an identity that transcends both the addictive history and the history of involvement with helping institutions. In a literal sense, this self-emergence is really not a "recovery" process, since recovery implies a recapturing or retrieval of something one once had. This is not retrieval of an old self; it is the creation of a new self. It is more a process of "becoming" than a process of "recovering."

Due to only four years of experience with Project SAFE, we don't know a lot about this stage of recovery for SAFE women. From the earliest success stories within the project, we do have inklings of some of the elements within this stage. It seems to be marked by:

- Movement toward one's personal aspirations, often reflected in achievement of some personal milestone, *e.g.*, completing high school, getting into college, and getting employment.

- Working through tendency to substitute other excessive behaviors, e.g., workaholism, food, and sex
- A maturing out of the narcissistic preoccupation with self that characterized active addiction and early stage recovery
- The creation of a social network in which relationships are characterized by mutual respect and support
- The organization of one's life around a set of clearly defined values and beliefs
- The emergence of acts of service to other people

There is tremendous diversity in how women within Project SAFE have experienced or failed to experience the recovery process. For some, sobriety and the enhancement of parental functioning were introduced into an otherwise unchanged life. For others, Project SAFE would represent the

beginning of a life-transforming recovery process. It is our hope that this paper has captured some of the shared experiences that transcend this diversity.

THE MANAGEMENT OF RESISTANCE IN THE TREATMENT OF ADDICTED WOMEN WITH HISTORIES OF CHILD NEGLECT/ABUSE THE PROJECT SAFE EXPERIENCE (1986-1996)

Resistance

Resistance is the totality of forces that inhibit change in the client.

Sources of Resistance

These forces can come from within the client (neurological deficits, prior victimization and abandonment), be exerted by the power of a drug over theclient (euph counter transference).

Types of Resistance

Resistance may be characterological, issue specific, relationship specific, or time specific.

Reality or Resistance?

What has often been called resistance in our clients is actually the reality of their daily lives that preclude consistent treatment engagement. These are addressed in Project SAFE through the provision of child care services, daily transportation and case management services designed to resolve problems that interfere with treatment.

Pain Threshold

The developmental trauma experienced by most Project SAFE clients produces an enormous capacity for pain and loss. As one outreach worker notes: “My clients don’t hit bottom; my clients live on the bottom. To suggest that these clients aren’t ready for treatment because they don’t have enough pain in their life is the ultimate in clinical arrogance. They have more pain than most of us could comprehend. The issue is not a shortage of pain and consequences; the issue is an absence of HOPE.”

Pain vs. Hope-based Interventions

Interventions that increase the client’s experience of pain and consequences without simultaneously inciting hope increase suicidal ideation and destructive flight. Hope-based interventions rely on an enduring, consistent relationship in which the client is forced to re-evaluate herself and her relationship with the world. In Project SAFE, the first of these relationships is with an outreach worker.

Empowering vs. Enabling

Interventions that would have been historically labeled “rescuing” or “enabling” when applied to addicted men may be essential strategies in the engagement of significant numbers of addicted women. The purpose of these strategies is to engage and then disentangle the client from what has become a chronic cluster of hopelessness, learned helplessness, passivity andesteem-sapping dependence.

Focus on Doing
Given the pervasiveness of the dependency cluster, clients are unlikely to want to participate in all that is required to initiate a recovery process. The treatment focus is not on the desire but on the doing. It is our experience that changes in the external behavior evoke changes in the client's internal emotional architecture. Treatment slogans such as "Act as If," "Fake it Til You Make It," and "Just Do It!" all reinforce this principle. The motivation to initiate and sustain this early leap into doing comes from the coaching and cheerleading of staff.

Motivation and Treatment Outcome
Motivation or lack of motivation at the time of initial contact is not a predictor of treatment outcome. Some of Project SAFE's most successful clients were among the most resistant and treatment-hostile clients at initial contact.

Source & Timing of Motivation
Motivation for recovery for our clients is not a pre-condition for entrance into treatment but something that emerges out of the treatment process itself.

The Change Process
Very few of our clients experience "conversion reactions" through which they suddenly cast aside their drug relationship and addiction-shaped lifestyle. The change process is more evolutionary than revolutionary.

Developmental Stages
There are developmental stages of recovery just as there are developmenta lstages of addiction. There is an essential sequence to these stages: certain tasks must be completed BEFORE other tasks can be achieved. Some tasksare time-dependent. Treatment interventions must be measured for effectiveness according to their stage appropriateness.

Unfreezing
The acquisition of new perspectives/behaviors requires an unfreezing of current perspectives/behaviors. Unfreezing poses opportunity and threat. In this state, the client is free to move forward or regress backward. Transitions are a great opportunity for leaps of growth and for the threat of regression and relapse.

Safety
The capacity of the client to unfreeze current perspectives/behaviors and move into this area of opportunity and threat requires that we provide an environment of encouragement and physical and psychological safety.

Self-defeating Styles
Most Project SAFE clients bring chronic self-defeating styles of relating to professional helpers. These frozen, superficial styles must be shed or clientswill either self-destruct their treatment experience or passively "do treatment."

Testing and Ambivalence	Most Project SAFE clients go through a sustained period of testing before they fully involve themselves in a treatment and recovery process.
Pre-Treatment	Programs must have the capacity to tolerate and work through this process of testing. This stage of engagement we call "Pre-treatment." It is a stage of relationship building and treatment readiness that is designed to enhance safety and trust, reduce environmental obstacles to recovery, and incite motivation for personal change.
Treatment Techniques	Techniques that are successful in lowering resistance vary across developmental stages of recovery. Early techniques focus on accepting the client in her own environment, listening, self-disclosing, and encouraging. These are later expanded to include such techniques as self-assessment exercises, teaching, modeling, mentoring, humor, contracting, story construction and story telling.
Developmental Maturation	Staff have observed that many of the most successful clients went through three overlapping stages in treatment: 1) resistance, 2) regression and dependence, and 3) developmental maturation. The latter stages of maturation often parallel those of healthy child/ adolescent development. Concepts such as "surrogate family" and "reparenting" help describe the therapeutic dynamic within Project SAFE treatment sites.
Positive Resistance	The resistance to change that is an obstacle to early recovery becomes an ally and a primary means of relapse prevention in later recovery.

SEXUAL TRAUMA AND SUBSTANCE ABUSE
DEVELOPMENTAL TRAJECTORY AND IMPLICATIONS FOR TREATMENT
THE PROJECT SAFE EXPERIENCE (1986-1996)

Prevalence — Substance abusing women who have neglected or abused their children have a much higher frequency of childhood sexual abuse (45-95% of clients admitted across 19 treatment sites) than do women surveyed from the general population (16-34% range in most non-clinical surveys).

Clinical Vs. Non-clinical Populations — There are differences in the nature of the sexual abuse experiences of women in clinical populations (women receiving substance abuse, psychiatric, eating disorder, or domestic violence-related services) compared to women in the general population who report having been sexually abused in childhood.

Comparative Factors — The distinctive aspects of the sexual abuse experiences of women in Project SAFE include specific traumagenic factors and the absence of protective/resiliency factors.

Traumagenic Factors — The majority of Project SAFE clients experience childhood sexual abuse that is characterized by the following traumagenic factors:

1) early onset of abuse (pre-latency),
2) long duration of abuse (most frequently measured in years),
3) multiple perpetrators,
4) perpetrators from within the family or whose presence was sanctioned by the family,
5) violence or threat of violence as an aspect of the abuse experience,
6) more boundary-invasive forms of sexual abuse, and
7) disbelief or blaming as a response to breaking silence (with resulting continuation or escalation of abuse).

Protective/ Resiliency Factors — Most women in Project also lacked protective/resiliency factors that could have prevented their victimization or could have provided nurturing and healing experiences that could have potentially mediated the long term effects of early victimization.

Role in Substance Abuse — Clinical staff working in Project SAFE often view the etiology of substance abuse as a process of self-medicating the sustained effects of emotional and

physical trauma.

Problem Multiplicity Substance abuse rarely presents itself as a single, self-encapsulated problem in Project SAFE clients. Most SAFE clients present with a broad spectrumof problems that cross all the boundaries of our categorically segregated health and human service systems.

Role of Trauma in Neglect/ Abuse It is the general view of Project SAFE staff that the SAFE client is higher risk for neglecting or abusing their own children NOT because of the FACT of their own developmental abuse but because of the INTENSITY AND DURATION OF TRAUMA reflected in that abuse. This risk is further increased by the absence of natural healing experiences--the absence of indigenous systems of support. The issue is as much what these clients didn't experience as what they did experience.

Asset-based Assessment Much of what has been framed as the pathology of Project SAFE clients--impaired capacity for trust, manipulativeness, flight (early runaway behavior), disassociation--can be reframed in light of their early abuse as strategies of survival. The ability to discover strength and recognize one's capacity for survival was an important foundation in the recoveries of Project SAFE clients.

Intergenerational Transmission Many of the problems of Project SAFE clients, including problems of substance abuse and physical/sexual abuse, seem to be moving in an inter-generationally pattern of self-accelerating intensity. There is great concern within Project SAFE about the need to break these intergenerational cycles of transmission.

Intergenerational Risk The children of Project SAFE clients are viewed as being at increased risk of sexual abuse due to the following factors:

1) Some of the perpetrators who sexually abused Project SAFE clients also have access to their children.
2) The propensity of Project SAFE clients to become involved in intimate partners who have multiple problems creates an "at risk" environment for their children.
3) There is an increase in the number of SAFE clients who themselves report having been involved in the sexual abuse of others.
4) Decreased supervision of children of drug using parents may increase the children's exposure to a broad spectrum of victimizing behaviors.
5) Having rarely experienced boundaries of appropriateness and having not been protected, Project SAFE mothers may have difficulties teaching such

boundaries and affording such protection to their children.

6) The dependence of a drug-using woman on her paramour for drugs, money and shelter contributes to the denial that this same partner may be physically or sexually abusing the mother's children.

Patterning The developmental trauma experienced by Project SAFE client often results in sexualized relationships with men and strained, often competitive or hostile relationships with other women. Project SAFE women describe as almost compulsive their propensity for involvement in highly toxic intimate relationships. This pattern carries into recovery and poses a significant threat of relapse.

Immediacy of Threat In addition to a history of early developmental violence, Project SAFE clients often are at increased risk of sexual exploitation and sexual assault in their later developmental years. Given this phenomenon of patterning, concern related to the immediate safety of project SAFE clients is a critical issue, particularly when these clients attemp to sever their involvement in these toxic relationships. Linkages with domestic violence resources is critical for Project SAFE sites.

Motivation for Treatment The developmental trauma of project SAFE clients produces an enormous capacity for pain and loss. As one outreach worker noted, "my clients don't hit bottom, my clients live on the bottom!" As a result, hope-based interventions often prove more effective in initiating and sustaining treatment involvement than pain-based interventions.

Motivation or lack of motivation at the time of initial contact is not a predictor of treatment outcome. Some of Project Safe's most successful clients were among the most resistant and treatment-hostile clients at initial contact.

Addiction to Chaos Chaos is an enduring theme in the lives of Project SAFE clients before and during the early stages of treatment. Adults survivors of sexual trauma learn how to use chaos (emergencies) strategically for emotional defocusing and intimacy management. Relentless relationship building and sustained case management is required to get through this "therapy in the middle of a hurricane" stage.

Excessive Behavior When project SAFE clients stop using drugs and bring their daily life into greater tranquility and predictability, they are vulnerable for the development of new excessive behaviors that ranged from eating disorders to gambling problems.

Diagnosis Many project SAFE clients come with prior histories of psychiatric diagnoses including from depression, anxiety disorder, and quite frequently borderline personality. Many staff prefer to reframe the characterological disturbances of SAFE

clients in terms of resilience rather than pathology. Viewing behaviors as temporally adaptive within a framework of traumatic stress disorder or Blume's "post-incest syndrome" proved more empowering and less stigmatizing than the more pejorative option of borderline personality.

Pre-Treatment

Clients with histories of developmental trauma require a longer period of time to engage in treatment. The earliest stages of engagement are marked by constant boundary and rule testing and by great ambivalence regarding treatment involvement. It is essential that programs have the capacity to tolerate and work through this testing period.

Developmental Stages of Recovery

Addressing childhood victimization for most Project SAFE clients continues in different ways through early, middle and late stages of addiction treatment. This is NOT an issue that can be postponed until late stages of recovery. At the same time, it is essential that each client remain in control of when, where, and to what degree of intensity this issue is addressed.

Some of the more common developmental stages in addressing sexual victimization include breaking silence about the victimization, sharing stories with other survivors, direct expression of anger to the perpetrator(s) (in some cases), linking sexual abuse experiences to other problem areas, identifying and self-correcting patterns of self-injury and self-sabotage, and reconstructing one's personal story and personal lifestyle.

Shame & Relapse

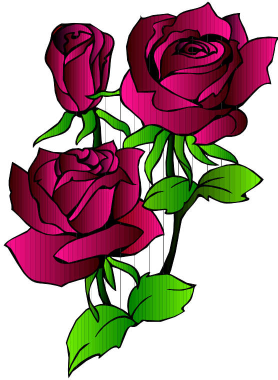
Shame (and its impact on self-esteem) is described as a core issue of treatment within project SAFE--an issue that often drives a wide spectrum of self-defeating and self-injuring behaviors. Clients are at high risk to relapse in response to intense experiences of success as they were to experiences of failure. Achievement of major milestones in treatment thus becomes a high risk time for relapse.

Iatrogenic Revictimization/ Boundary Surveillance

Clinical staff of Project SAFE recognize that there is a danger in revictimizing their clients at both ends of the intimacy continuum. The potential for abandonment and over-involvement with these clients is quite high. Monitoring the migration toward either end of this continuum is essential for all caregivers.

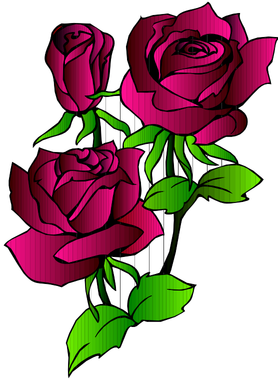
Interventions which violate the defense structure of the client through invasive and coercive attempts at eliciting behavioral change recapitulate historical victimization. Such interventions are more likely to trigger aggression or flight than positive behavioral change.

Safety	Great care has to be taken to assure the physical and psychological safety of Project SAFE clients within the treatment milieu. Some clients have been so damaged (by male perpetrators) that they require a gender-exclusive environment in which to initiate their recovery. In addition, some clients have been so traumatized in relationships of unequal power that they are more likely to initiate recovery in mutual aid groups or low intensity modalities within which the client has significant control over the degree and pace of emotional intimacy. Clients did best in women's groups and in meetings filled with persons from the same geographical and cultural background. Clients did the least favorably in mutual support groups characterized by a weak "group conscience," e.g, sexualized rather than emotionally supportive relation-ships.
Victim Vs. Survivor	Most Project SAFE clients go through a "victim" stage in which their whole identity and life history is viewed in terms of the issue of victimization. Staff can learn to recognize and work through this stage rather than to try to avoid this stage.
Termination Problems	Project SAFE clients are hypersensitive to issues of loss and abandonment. Program "graduations" have to be carefully phased to avoid emotional regression and relapse. Anticipation of the end of treatment (and membership in the treatment community) and even anticipation of the end of DCFS involvement and the structure such involvement provides poses risks of relapse and have to be carefully managed.
Duration of Treatment	The fact that most Project SAFE clients required longer periods of treatment than other clients to achieve and sustain sobriety, emotional stabilization and positive parent-child relationships was related to four inter-related factors: 1) gross developmental deficits, 2) a high number, variety and intensity of presenting problems, 3) significant environmental obstacles to recovery, and 4) an extended period of testing that preceded full treatment engagement.



THE DELIVERY AND SUPERVISION OF OUTREACH SERVICES

Part II:
The Supervision of Outreach Services



The Supervision of Outreach Services

Project SAFE

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1.0 Recruitment and Selection of Outreach Workers

Learning Objectives

1. Identify at least four qualifications essential to the delivery of effective outreach services to women in Project SAFE.
2. Describe four different sources for outreach worker recruitment.
3. Discuss methods of screening outreach worker candidates.
4. Discuss ethical and boundary issues that can arise in the hiring and supervision of recovering people working as outreach workers.

The Ideal Outreach Worker: Qualities, Experience, and Knowledge

Voices of Hope: An Orientation Manual for Outreach Workers includes a discussion of the kinds of knowledge, skills, and temperament it takes to function as an outreach worker serving addicted women and their families. In this section we'll try to focus our discussion on the kinds of qualifications that can be used to recruit and screen outreach worker candidates. Given your understanding of your project, the characteristics and needs of your clients, and the characteristics of other team members who will be working with the outreach worker, answer the following questions.

1. What do outreach workers need to know and understand? What understandings form the foundation for effective outreach services? What combination of education and life experience would indicate that a candidate has this understanding?

 ____

 ____

 ____

 ____

 Complete the checklist below with items from your discussion:

 ___ Knowledge of addiction and recovery

 ___ Knowledge of the special needs of addicted women

 ___ Knowledge of the local community—neighborhoods, resources, etc.

 ___ Knowledge of parenting/family life

 ___ Knowledge of abuse/neglect of children

 ___ Knowledge of community cultures

 ___ Knowledge of confidentiality requirements

 ___ ____

___ ____

___ ____

___ ____

Circle the four areas that you consider most important.

2. What do outreach workers need to be able to do? What skills must outreach workers have, and what tasks must they be able to perform?

____

____

____

Complete the checklist below with items from your discussion.

___ Verbally persuade

___ Organize

___ Solve Problems

___ Listen

___ Advise

___ Write

___ Drive safely in spite of distractions

___ Make good decisions independently

___ Speak Spanish or _______________

___ "Join" skills with client/family

___ Separate behavior from the person (not take the client's behavior personally)

___ Separate personal recovery from professional responsibility

___ ______________________

___ ______________________

Circle the four that you consider most important.

3. What do outreach workers need to be? What kind of person does it take to perform this role well over time?

____

____

____

Complete the checklist below with items from your discussion.

___ Assertive

___ Patient

___ Tenacious

___ Naturally nurturing

___ Realistic

___ Reliable/dependable

___ Open-minded

___ Creative

___ Having a sense of humor

___ Fearless (in a smart way)

___ Determined

___ __________________

___ __________________

___ __________________

___ __________________

___ __________________

Circle the four that you consider most important.

Where to Recruit Outreach Workers

Approaches to effective outreach worker recruitment vary from community to community and from agency to agency. In reviewing our experience in Illinois over the past decade, supervisors have identified the following methods as potential strategies for outreach worker recruitment. Check those that you currently use and circle those that could enhance your outreach worker recruitment efforts.

___ Recruiting from other programs within the agency

___ Recruiting outreach workers from the pool of successful agency clients

___ Recruiting through the AA/NA/CA and Al-Anon grapevine

___ Advertising through the local newspapers

___ Recruiting through local indigenous community leaders

___ Sending announcements of openings to other agencies that work with women

___ Recruiting through the local community colleges

___ Asking local ministers to help recruit potential outreach worker candidates from their congregations

___ Posting openings in local community centers

___ Recruiting from therapist applicants who don't have the experience/qualifications to be hired as therapists

___ Using the personal contacts of existing outreach workers and case managers

___ Using a volunteer program as a pool of people from which to develop and recruit potential outreach workers

___ ____

___ ____

___ ____

Screening Candidates

Some people who may be drawn to the role of outreach worker may not be appropriate for this role. They might lack adequate knowledge and skills, or they might have certain characteristics of temperament that make them unsuitable to work with addicted women. Based on your experience, what kinds of people would you try to screen **out** of the applicant pool? (Reflect on such issues as knowledge, personality, motivation, stability, and moral character.)

1. ____
2. ____
3. ____
4. ____
5. ____

Describe interview questions that help you identify candidates who would not be appropriate to work as outreach workers in your program.

1. ____
2. ____
3. ____
4. ____

Issues in the Recruitment and Supervision of Recovering People

There are a number of special issues that can arise in the recruitment and supervision of recovering people who are working as outreach workers. In the space below, we'll review a number of these issues.

A. Recruitment Issues

Mary, a former client who completed treatment four months ago, has applied for an open outreach worker's position. She did very well in treatment and has established what appears to be a solid program of continuing recovery. She has many skills that you're looking for in an outreach worker. She has a good basic understanding of addiction, treatment, and recovery. She knows the community well. She's highly motivated to work with addicted women and has above-average intelligence and excellent verbal skills. Your concern is that Mary has only seven months' sobriety at this point. What pitfalls might there be in hiring Mary as an outreach worker, given this short period of sobriety? What minimum length of sobriety do you believe is necessary for someone to work effectively as an outreach worker?

____

____

____

____

Sharine is a former client with two years' sobriety who has applied for an outreach worker's position. Like Mary in the above vignette, Sharine has many qualities that would make her an ideal outreach worker. Your concern about Sharine is whether her style of recovery is compatible with effective outreach work. Sharine is a "true believer" in the particular way she's maintaining her recovery, and is prone to excessive self-disclosure. While she has great passion for recovery and great motivation to work with other addicted women, what problems might her style pose in the role of an outreach worker? If Sharine were hired, how might these issues be addressed in supervision?

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____

Addiction treatment agencies have been hiring recovering people for more than a century to work as part of interdisciplinary treatment teams. In screening recovering people for potential employment in the field, this question often arises: How do we assess whether a job candidate who presents as a recovering person has a stable and durable program of recovery? In addition to establishing and sticking to length-of-sobriety requirements, programs have found that they can often recognize recovering people with the strongest programs of recovery by the following:

- knowledge of recovery literature
- sponsorship (both having a sponsor and having sponsored others)
- past residence in a group home
- regular rituals of participation
- active application of the Steps

- a period of independent functioning separate from agency support (for former clients applying for outreach workers' positions)

Although these elements are based on people in Twelve-Step recovery, candidates who use alternative recovery pathways (for example, religion) can often be assessed for similar elements.

Observations from outreach workers and supervisors on the recruitment of recovering people to work as outreach workers included the following:

> *You need to find people who are naturally therapeutic and nurturing. The issue of whether a candidate is recovering is secondary.*
>
> *Recovering people bring some special capacities for empathy and understanding to their work, but it's important to realize they may also bring special vulnerabilities. Working as an outreach worker can bring back a lot of memories, and if you haven't dealt with some of the stuff your clients are going through, it can all come back and slap you in the face.*
>
> *I think those of us who are recovering have an inclination for over-involvement with clients because we know what the stakes of success and failure are. When you start crying all the time and all your thoughts and conversations are focused on clients, you're getting too attached. It's like we're working the program instead of them working the program.*
>
> [Recovering people working as outreach workers] *are going to face some threats to their recovery, so it's important that recovering people have a good deal of sobriety time and a good program of recovery. Sometimes you're walking into places filled with booze or cocaine—you're seeing it and smelling it. It can be risky for people who have only a fragile hold on their own sobriety.*
>
> *It's important to hire* [recovering] *people who understand that the client cannot recover exactly the same way that they did.*

B. Ethical and Boundary Issues

Chapter Four in *Voices of Hope* includes a general review of some of the ethical and boundary issues that can arise in the delivery of outreach services. After reviewing this material and reviewing the "AA Guidelines for AA Members Employed in the Alcoholism Field," complete the following two exercises.

There are special ethical and boundary issues that arise for recovering people working professionally in addiction treatment settings. Discuss with your outreach worker how she or he would evaluate each of the following activities using the following designations, and write the answers in the spaces below:

A=Always Okay
S=Sometimes Okay
N=Never Okay.

___ Agreeing to serve as an AA/NA/CA sponsor of a client currently in treatment

___ Sharing the fact of your recovery status with a client

___ Telling intimate details of "your story" to a client.

___ Agreeing to hear a client's Fifth Step

___ Attending AA/NA/CA meetings where current clients are present

___ Attending AA/NA/CA social functions where current clients are present

___ Transporting a client to an AA/NA/CA meeting or social function

___ Developing a personal friendship with a current/former client

___ Developing a sexual relationship with a current/former client

___ Developing a sexual relationship with someone from a current/former client's family or intimate social network

___ Disclosing your status as a recovering person in public settings

___ Disclosing your AA/NA/CA affiliation in public settings

Sometimes agencies can inadvertently contribute to the kind of role conflict that recovering people experience working professionally in addiction treatment settings. Comment on the following practices:

- Requiring AA/NA/CA attendance as part of one's job responsibilities
- Requiring participation with clients in AA/NA/CA functions as part of one's job responsibilities
- Announcing to visitors that two of your program staff are AA/NA/CA members
- Assigning a recovering staff person to serve as a liaison and resolve problems that arise with local AA/NA/CA groups
- Asking recovering staff members to share their stories in a public setting as part of their job responsibilities

What other practices have you seen that you thought contributed to the double-bind that recovering people sometimes experience working in addiction treatment settings?

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One of the most difficult situations any supervisor in addiction treatment can experience is the relapse of a recovering person who is working within his or her program. Consider the following scenario:

Alicia is a self-identified recovering person who has worked as an outreach

worker in your program for the past nine months. When she was hired she had three years' sobriety and prior employment as an outreach worker. You've noticed a number of changes in Alicia the past two months and have raised your concern about some of these changes in supervision. Alicia has consistently said that she's just going through a rough time right now but that she'll be fine. Following each of these discussions, her performance has improved for a period of time and then begun to deteriorate again. Today two of your staff tell you that they believe Alicia is using gain. Both have smelled alcohol on her in the past week. When you confront Alicia, she breaks down and confesses that she's been secretly drinking for the past month.

How would you respond to this situation? What supervisory options are available to you? If Alicia went to treatment, would she be allowed to continue as an outreach worker? How has your agency responded to situations like this?

____

____

____

____

Salary and Benefits: A Brief Comment

We asked all of those interviewed in the preparation of this manual about their views on the role of salary and benefits in recruiting and keeping outreach workers. Salary ranges for outreach workers (noted in the Spring of 1996 interviews) were between $14,000 and $20,000. There was a general consensus that the lower end of this range was inadequate and contributed to a high level of staff turnover among outreach workers. When asked which benefits were most important to recruiting and retaining good outreach workers, they generally agreed that financial support for continued education and potential for career advancement within the agency were the two benefits that outreach workers found most attractive.

Reading Resources

AA Guidelines for AA Members Employed in the Alcoholism Field. New York: Alcoholics Anonymous.

Bissell, L. And Royce, J. (1994). *Ethics for Addiction Professionals.* Center City, Minnesota: Hazelden.

White, W. (1993). *Critical Incidents: Ethical Issues in Substance Abuse Prevention and Treatment.* Bloomington, Illinois: Lighthouse Institute.

Working as, for or with Professionals. New York: Al-Anon Family Groups

2.0 Orientation, Training, and Professional Development

Learning Objectives

1. Describe three strategies for outreach worker orientation.
2. Discuss approaches to assessing the professional development needs of outreach workers.

Orientation Strategies

The orientation period for a newly hired outreach worker is important for many reasons. This period:

- begins the relationship between the supervisor and the outreach worker,
- ntegrates the outreach worker into the interdisciplinary team,
- sets the beginning structure for supervision, and
- initiates the outreach worker into her or his job responsibilities.

During the orientation period the outreach worker is grasping a basic understanding of program clients, and of the overall philosophy and operation of the treatment setting.

Some of the most frequently used methods or orientation for outreach workers include the following:

1. *Supervisory Coaching:* Most supervisors provide a formal orientation program for newly hired outreach workers, lasting from one to four weeks. During this period the outreach worker is oriented to her or his duties and given basic background information on addiction and its treatment. One option for the orientation of new workers is for the supervisor to use the Modules in *Voices of Hope: An Orientation Manual for Outreach Workers* as a vehicle of new employee orientation.

   Once the outreach worker begins to assume the job responsibilities, a daily review of assignments and daily debriefing of significant events can provide initial support and help solidify the relationship between the supervisor and the outreach worker. Supervisory contact is usually much more frequent during this orientation period than in the regular structure of supervision, which is discussed in a later module. Using other team members to provide part of this initial orientation and training can also be helpful in speeding the integration of the new worker into the team.

2. *Internal Mentoring:* One of the most effective methods of outreach worker orientation is to establish an internal mentoring program through which the newly hired outreach worker is paired with another, more seasoned outreach worker. In some programs, the new outreach worker accompanies the senior outreach worker for the first few weeks, until he or she becomes fully acclimated to the outreach worker's role and responsibilities. Internal mentoring is quite useful in light of the fact that outreach workers work so closely together. Internal mentorship programs can speed team building between outreach workers and minimize competition and conflict. Where an outreach worker is hired into an agency that has no one currently working in an outreach role, a program of external mentoring may be helpful.

3. *External Mentoring:* External mentoring is a process by which an outreach worker in one agency is linked with other outreach workers from one or more other agencies. This might be done by having senior outreach workers from other areas serve as temporary consultants to a newly hired outreach worker, or by having the newly hired outreach worker spend part of her or his orientation period working with an outreach worker from another agency whose philosophy of treatment or outreach is similar to that of the home agency. Where time and budget constraints prohibit this kind of staff exchange, telephone interviews of seasoned outreach workers by newly hired outreach workers provide an economical alternative. Another mode of external mentoring is providing opportunities for new outreach workers to network with their counterparts from other parts of the state in the periodic training conferences sponsored by DCFS and DASA.

What other methods of outreach worker orientation are used at your agency?

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____

____

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____

Assessing Knowledge and Skill Deficits

It's possible to take the knowledge and skill areas discussed in the module on recruitment to create a format for the evaluation of an outreach worker's level of knowledge and skill development. It's important that this process be used, not as a source of criticism, but as a vehicle for personal and professional development. Checklists like the following can be used as self-assessment inventories that are then reviewed with the supervisor. A sample format for such a self-inventory is illustrated on the following page.

SAMPLE
Professional Self-Assessment Inventory

Before each of the knowledge and skill areas listed below, rate your current level of proficiency by placing one of the following letters: S=Strength; A=Adequate in this area; N=Need Training and Supervision in this area.

Knowledge Areas

___ history of addiction and its treatment
___ drugs of abuse/drug trends
___ the process and progression of addiction
___ gangs and the culture of addiction
___ HIV/AIDS
___ domestic violence
___ sexual abuse
___ needs of addicted women
___ substance abuse treatment modalities
___ special needs of addicted women
___ developmental stages of recovery in women
___ sobriety-based mutual-aid groups
___ mandatory reporting requirements related to neglect/abuse
___ ethical and boundary issues in service relationships
___ community resources
___ ethnic cultures
___ ________________________________
___ ________________________________
___ ________________________________

Skill Areas

___ sensitivity to safety issues involved in transporting clients
___ assessing environments for safety threats
___ reducing and working through resistance
___ engaging and motivating clients
___ listening and communication skills
___ conducting home visits
___ crisis intervention and problem solving
___ resource identification and resource linkage
___ monitoring abuse/neglect issues
___ working with family members
___ assessing the needs of children
___ organizing activities and managing time
___ re-engaging clients
___ __________________________________
___ __________________________________
___ __________________________________

Initial Professional Development Plan

The best way to prepare an initial professional development plan for an outreach worker is to focus on the following four questions in a meeting or series of meetings between the outreach worker and her or his supervisor:

1. What strengths of character, knowledge, and skill does the outreach worker currently possess?

2. What areas of character, knowledge, and skill need further development?

3. What are the outreach worker's personal and professional aspirations?

4. What internal and external resources can be used to enhance the professional development of this outreach worker?

The answers to the first two questions may differ according to the needs of each particular program, just as the answer to the last question will differ greatly by agency and by geographical area of the state. The identification of character, knowledge, and skill requirements in the last module can be used to create a format for professional development planning in meetings between the outreach worker and the supervisor.

Assessing Vulnerabilities of Temperament/Style[2]

One of the most difficult vulnerabilities to identify is not knowledge or skill deficiency, but a personality or interaction style that might undermine an outreach worker's effectiveness. Some of these kinds of problems might be enduring, or they might be temporary and intermittent—most often showing up during periods of high stress.

While the temporary signs of stress were addressed in the module on stress and self-care in *Voices of Hope,* the enduring personality/interaction styles can be addressed within the umbrella of personal/professional development. The following is an exercise that can be done with all staff, or in one-to-one supervision sessions that address these issues in a framework that ensures some degree of psychological safety.

[2] This exercise is adapted from a training activity developed by Steven Guerra.

Listed below are traits or values that outreach workers can show in their interactions with clients and co-workers:

Achievement	Honesty	Arrogance
Emotional Stability	Callousness	Leadership
Intelligence	Respect	Vision
Unpredictability	Calm	Passion
Spirituality	Compassion	Hopefulness
Insensitivity	Sloppiness	Cooperation
Religiousness	Pragmatism	Creativity
Risk-taking	Charisma	Dictatorship
Disorganization	Rigidity	Narcissism
Wisdom	Intuition	Friendliness
Rudeness	Motivation	Forgetfulness
Laziness	Carelessness	Self-righteousness
Flamboyancy	Slowness/Tardiness	Tendency to gossip
Disloyalty	Lack of realism	Common sense
____________	___________	____________
____________	___________	____________

List below the three traits/values you feel represent the strongest and most desirable traits of character that you bring to the workplace.

1. ____________________________ ____
2. ____________________________ ____
3. ____________________________ ____

In the right-hand column, note any problems that could be created if each trait were carried to an extreme level. The point of this exercise is to discover ways in which even the best of traits can become problems when they're carried to an extreme. For example, confidence becomes arrogance, punctuality becomes compulsiveness, and achievement becomes workaholism.

From the same list, identify the three traits/values in other people that you most dislike.

1. ____________________________ ____
2. ____________________________ ____
3. ____________________________ ____

In the right-hand column, see if you can identify any situation in which you exhibited the same traits. The purpose of this exercise is to explore how the things we most detest in others may be projections of unacceptable parts of our own character—parts that we might not be able to see in ourselves. What we hate can tell us as much about ourselves as what we love.

Team Building

Many people interviewed for insights into the supervision of outreach workers noted that a natural tension existed between outreach workers, people in other roles within the agency, and workers from other agencies who shared responsibility for service delivery with the outreach workers and therapists. They further noted that people in these roles worked together best when there were activities that brought them together to enhance their personal/professional relationships and their effectiveness as a team.
What kinds of activities might make it easier to integrate outreach workers into the agency team and into the broader community team that serves your clients?

1. ________________________________ 3. ____________________________________

2. ________________________________ 4. ____________________________________

Ongoing Professional Development Activities

For the past five years, Project SAFE evaluation reports have called for the "professionalization" (in the best sense of this term) of the role of outreach worker through the development of preparatory programs, access to continuing education benefits, the creation of adequate salary structures, and the conscious development of career paths/ladders for outreach workers within the agencies in which they work. Our focus here will be on the last of these recommendations.

One of the more fulfilling aspects of supervision is participating in the long-term development of supervisees. This involves two processes: creating career development options and starting a formal program of professional development planning. What career advancement options are available to outreach workers at your agency?

____

What kinds of education, training, and work experiences are necessary to have these options?

____

A formal program of professional development planning can be incorporated into your process of annual performance review, or it can be kept separate from the evaluation processes. The format on the following page is one that has proven helpful in guiding professional development planning meetings between the supervisor and outreach worker. After reviewing the format, note below how you might use this format or modify it for use within your agency.

____

____

____

Professional Development Plan

Employee____

Date Plan Finalized/Revised____

Date Set for Next Review____

1. My current strengths of character, knowledge, and skill (use the checklists from the last module and the last exercise to make it more specific):

2. Situations/responsibilities I find most difficult or fear that I might encounter:

3. Areas of character, knowledge, and skill that need further development (use checklists from the last module to make it more specific):

4. My personal and professional hopes and aspirations for the next five years:

5. Professional development resources that are accessible, affordable, and relevant to my needs:

6. My professional development plans for the next year are to:
   1. ____
   2. ____
   3. ____

3.0 The Supervision of Outreach Workers

Learning Objectives

1. Identify the obstacles most often encountered in supervision, and the skills that help you overcome those obstacles and deliver effective supervisory services.
2. Identify the structure and focus of your supervisory duties.
3. Identify the supervisory methods that are appropriate for your site.
4. Discuss the caseload management techniques that you employ.
5. Discuss a variety of boundary issues that sometimes arise in supervision.

Obstacles to Effective Supervision

There are many things that can interfere with the consistent delivery of effective supervision. In the space below, identify the obstacles you most frequently encounter in providing supervision to the outreach workers at your program.

________________________________ ________________________________

________________________________ ________________________________

________________________________ ________________________________

Skills of an Effective Supervisor

Outreach workers across Illinois were asked to identify the most important skills and qualities needed for effective supervision of outreach services. Their responses fell into the following thirteen categories.

___1. Involvement: The ability to respect and support the outreach worker on a personal level without becoming intrusive.

___2. Flexibility: The capacity to alter the style and focus of supervision to meet the individual needs of each outreach worker.

___3. Modeling: The ability to teach by modeling appropriate attitudes and skills when relating to clients.

___4. Encouragement: The ability to convey optimism and faith in clients' capacity to change, and to convey the important role outreach workers can play in supporting that change.

___5. Direction: The ability to guide the outreach worker through the resolution of difficult situations.

___6. Patience: The ability to nurture the progressive maturation of the outreach worker's knowledge and skills through evaluation and teaching.

___7. Advocacy: The ability to represent the interests of the program and the needs of the

outreach workers, both within the agency and with outside funding and regulatory agencies.

___8. Courage: The ability to confront difficult issues that arise in staff-client and staff-staff relationships.

___9. Humor: The ability to laugh—at oneself, and within one's daily interactions with staff and clients.

__10. Communication: The ability to serve as a switchboard for information within the program, linking and coordinating people and activities.

__11. Technical Competence: The ability to bring to the program and its staff a high degree of clinical knowledge about the treatment of addicted women and their children.

__12. Self-Awareness: The recognition of one's own biases, deficiencies, and limitations.

__13. Accessability: Availability to respond to questions, provide direction, and help with problem solving.

Using this list, rate your current performance as a supervisor by placing the appropriate letter in front of each of the thirteen dimensions of supervisory effectiveness.

S= Personal Strength
A= Personal Adequacy
N= Area of Needed Development

Which of the above dimensions do you believe is most important to your further development?

____

How might you go about strengthening this dimension of your role as a supervisor?

____

____

____

The Structure of Supervision

Note the current structure you use in supervising outreach workers, by checking all of the following items that reflect regular supervisory activity.

___ One-to-one supervision: supervisor/outreach worker

___ One-to-one supervision: clinical staff or consultant/outreach worker

___ One-to-one supervision: outreach worker/outreach worker (tandem or peer)

___ Individual supervision: outreach worker/multiple supervisors (each supervisor focusing on different activities or different areas of skill development)

___ Group supervision: supervisor with outreach workers

___ Group supervision: supervisor with all agency team members

___ Group supervision: supervisor with workers from within and outside the agency.

___ Group supervision: outreach workers without supervisor ("peer/tandem supervision")

___ Group supervision: all team members without supervisor ("peer supervision")

___ Other ____

___ Other ____

Which of the above do you find most useful in supervising outreach workers? ______________

____

____

Describe how the timing of supervision of outreach workers is structured in your program by checking all of the items below that are appropriate.

___ Time is consistently set for supervision and adhered to

___ Time set for supervision but often compromised

___ "PRN" supervision: "Let me know when you need me."

___ Supervision of assignments and debriefing of significant events occurs daily

___ Supervision of assignments and debriefing of significant events occurs weekly

___ Team meetings are held at least weekly

___ ____

___ ____

What changes, if any, would you like to make in the timing of supervision within your program?

____

The Focus of Supervision

There are many aspects of, and many activities involved in, the supervision of outreach services. Check the activities below that currently take up the largest amount of your time:

___ Assigning cases

___ Reviewing daily activity assignments

___ Conducting case reviews

___ Internal problem solving

___ Reviewing documentation

___ Working with clients in conjunction with clinicians and outreach workers

___ Reviewing inter-agency relationships and issues
___ Addressing the personal problems of outreach workers
___ Monitoring travel—pick-ups, drop-offs, etc.
___ Educating/training
___ Other ______________________________________
___ Other ______________________________________

Many supervisors we interviewed stressed the importance of a high frequency of supervisory contact with outreach workers. The following is typical:

> *I maintain an open-door policy with my outreach workers, in addition to formal supervisory meetings. We are in a state of constant communication. I want outreach workers to be able to come and say, "This is what happened today—Did we do okay?" or "I'm not comfortable with what I said in this situation; how could I have said it differently?" Supervision is all of that give and take, not just what happens in our daily or weekly meetings.*

Supervisory Methods

Which of the following strategies or techniques of supervision would be appropriate for you and your setting? Check those that you currently use and place an X by those that you might consider using more often in the future.

___ Periodically riding with the outreach worker to pick up or drop off clients
___ Periodically going with the outreach worker on home visits
___ Doing formal case reviews with each outreach worker
___ Doing chart audits to monitor outreach worker documentation
___ Using a case presentation method in individual/team supervision
___ Using a critical-incident presentation method in individual/team supervision
___ Using an interdisciplinary case-planning conference
___ Using role playing in supervision
___ The use of reading assignments and discussion
___ Visits to other women's service programs
___ Clinical technique demonstrations
___ Use of audiotape or videotape
___ Other____
___ Other____

Caseload Management

The delivery of effective outreach services requires a particular chemistry in the relationship between the outreach worker and the client. Sometimes that chemistry can become quite toxic and severely undermine our ability to serve a particular client. Describe how you manage situations in which there appears to be a horrible mismatch between the elements that the client and the outreach worker bring to this relationship.

____

____

____

Boundary Issues in Supervision

At times, complex issues can arise concerning the appropriateness of certain actions within the supervisor-supervisee relationship. In the space below are a number of vignettes illustrating various boundary issues in supervision. Comment on what you perceive to be the appropriateness or inappropriateness of the supervisor's action in each vignette.

> *Mary has been supervising outreach workers at her agency for three years. She and one of her outreach workers are involved in the same Twelve-Step recovery program. This outreach worker asks Mary to be her sponsor; Mary agrees because they have a good relationship, and the outreach worker has had difficulty making new relationships within the recovery community. How would you have responded if you were Mary? What problems might arise in this dual relationship between Mary and her outreach worker?*
>
> Comments and Observations:______________________________
>
> ____
>
> ____
>
> ____

The following vignettes illustrate quite different approaches:

- *Betty is an outreach worker supervisor who is all business. Her supervisory sessions are always task- and client-focused. Issues related to the personal lives of outreach workers never arise in supervision, even when such issues may be spilling over into and affecting service relationships.*
- *Tanya supervises three outreach workers whom she knows very well. Whenever Tanya believes that an outreach worker's own emotional history might be interfering with her relationship with a particular client, or with her views on a particular clinical issue, she makes a point of mentioning this in individual supervision. She raises these kinds of questions for the outreach worker to reflect upon, as a way of improving her relationship with a particular client. Tanya never probes into these personal issues, nor would she allow supervisory time to*

be used to counsel the outreach worker on personal issues.

- *Rene, a third outreach worker supervisor, has quite a different style. She takes a maternal approach toward her outreach workers, is quite involved in issues related to their personal lives, and often offers advice related to their personal problems. There are many supervisory sessions in which more time is spent on the outreach worker's personal problems than on the problems of her clients.*

Compare and contrast these three approaches to boundary issues in supervision. Which styles could do potential harm to clients, to individual staff, and to the program?

Comments and Observations:____

____

____

____

____

Marta supervises two outreach workers and three counselors. She regularly socializes with one of the outreach workers and one of the counselors. In fact, the three are almost inseparable away from work. How might these dual relationships affect Marta's relationships with the other team members? What kinds of problems might occur in these outside relationships that might interfere with Marta's effectiveness as a supervisor? What stance do you believe is most appropriate regarding a supervisor's outside-of-work relationships with those she supervises?

Comments and Observations:____

____

____

____

____

Susan supervises three outreach workers and four counselors. Linda, one of the outreach workers, has told Susan that she may have to take some time off because her dad has been diagnosed with terminal cancer. A week later, one of the counselors approaches Susan and complains about Linda's recent habit of forgetting to return phone calls to DCFS. Susan tells the counselor that she'll talk to Linda about the problem, but asks the worker to give Linda some slack and support, because "Just between you and me, she's going through a really tough time right now. You see, her dad has been diagnosed with cancer." How would you have handled this situation? What issues are raised by Susan's disclosure of personal information about Linda drawn from the supervisory relationship?

Comments and Observations:____

____

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____

____

Joyce, a supervisor at a women's addiction treatment program, goes to a comedy club on a visit to a neighboring city. In the middle of the performance she looks across the room and sees one of her outreach workers, a self-described "recovered alcoholic," drinking alcohol. If you were Joyce, how would you respond to this situation? Is the drinking behavior of a self-proclaimed recovered alcoholic on Saturday night a gross violation of professional conduct or a non-work-related behavior that is none of the agency's business? There has been no deterioration in this worker's job performance. If you were going to confront the worker about this outside-of-work behavior, what agency or professional standard would you use as the basis of your confrontation?

Comments and Observations:____

____

____

____

____

Reading Resources:

Broadwell, M. (1984). *The New Supervisor.* Reading, MA: Addison-Wesley Publishing Company.

Powell, D. (1980). *Clinical Supervision: Skills for Substance Abuse Counselors.* New York: Human Science Press.

Wilson, L. (1981). *Field Instruction Techniques for Supervisors.* New York: The Free Press.

4.0 Enhancing the Safety of Outreach Workers

Learning Objectives

1. Discuss at least four strategies for enhancing the safety of outreach workers in the field and the safety of clients and staff at the service site.
2. Identify at least six clinical risk factors that increase the likelihood of violent aggression.

The Importance of Safety Issues in Outreach

Safety is an essential issue within women's service programs in Illinois. During the past decade:

- Outreach workers have lost clients to murder.
- Outreach workers and clients alike have been caught in the crossfire of gang violence.
- Angry paramours have stalked clients to the service offices.
- Gang members and drug dealers have approached outreach workers demanding to know who they are.
- Clients have made verbal threats toward outreach workers.
- Clients have carried weapons with them to the agency.
- Disgruntled ex-employees have made threats toward agencies in which outreach workers were employed.
- Outreach workers have walked into situations of domestic violence while conducting home visits.

Physical and psychological safety is an important issue for the women and children we serve, and for all involved in the service-delivery process.

Hiring and Orientation

In the space below, identify at least four factors that you might consider in the hiring and initial orientation of outreach workers, in order to enhance the effectiveness and safety of outreach workers in the field.

1. ____
2. ____
3. ____
4. ____

Target Hardening: Reducing Personal Vulnerability

"Target Hardening" is a strategy used by neighborhoods and institutions to lower their vulnerability to violent attack. For example, target-hardening strategies in a violence-plagued school might include the use of metal detectors at all entrances, the employment of security guards, the use of parent volunteers along school routes and on the school grounds at the beginning and end of the school day, and release times staggered by age or grade level. In the following exercise, you'll apply this concept of target hardening to your own service office.

Consider your office to be the target of a disgruntled, potentially violent client or ex-client, or the target of a violent paramour whose partner has just told him by phone that she's leaving him. Walk through your facility with this situation in mind and answer the following two questions:

1. What aspects of this environment would enhance the safety of staff and clients?

   ____

   ____

   ____

2. What aspects of this environment fail to protect clients and staff adequately?

   ____

   ____

   ____

List two things you can do to increase the safety of your service site:

1. ____
2. ____

The concept of target hardening can also apply to individuals who work in the field. Describe what advice you might give to your outreach workers related to the following:

Personal dress______________________________________

Color of outer clothing______________________________

Hats____

Jewelry____

Carrying money/valuables____________________________

Eye contact____

Vehicles____
_

Attitude____

Surveillance of the environment_______________________

Working in pairs____

Instincts____

General Strategies of Safety Enhancement

Rate the use or possible use of the following strategies in your program, using the following symbols:

C=Currently using

P=Would have potential at our program/will consider using

W=wouldn't work or wouldn't be possible at our site

___ Orienting all outreach workers to high-risk areas of communities being served

___ Conducting safety-related training for outreach workers

___ Maintaining liaison with local police department and security forces, such as security staff in public housing complexes

___ Equipping outreach workers with cellular phones

___ Equipping outreach workers with beepers

___ Rating neighborhoods or particular locations as low, moderate, or high risk

___ Conducting some "home visits" in the agency van or car, rather than in the client's home

___ Teaming two outreach workers together to conduct home visits in neighborhoods or sites rated as high risk

___ Establishing specific safety guidelines for conduct within the van or car

___ Offering self-defense classes for outreach workers

___ Scheduling home visits at lower-risk time periods (for example, morning rather than late afternoon or evening)

___ ____

___ ____

___ ____

___ ____

Critical Incident Training

Critical incident training is a case-study approach to building a worker's understanding and problem-solving skills. The training provides a safe environment in which in which one can think through all of the options in responding to a potentially difficult situation. The following situations are samples of critical incidents that might be used for inservice training of staff. Trainees should be asked to read each of the situation descriptions, then answer the following questions:

1. Would you rate this situation as a low, moderate, or high risk to your safety? If the information is inadequate, what else would you need to know in order to assess your risk?
2. What possible courses of action might you take? How would you handle this situation?
3. What standards (ground rules, advice) might guide other staff who found themselves in a similar situation?

Situation #1: *You are in the field conducting home visits. The client you're going to see lives in a building with a large number of apartments. There are often many men drinking in the parking lot or the building's porch, but today there are only two elderly men talking to one another. However, as you approach the apartment of your client, you hear very loud voices from inside the apartment. You recognize the voices as those of your client and her paramour. You can tell from the sounds coming from within that they're involved in a fight that is both verbal and physical, and of great intensity.*

Risk: ___Low ___Moderate ___High

Possible Courses of Action:____

____

____

Standards to guide staff:____

____

____

Situation #2: *You're approaching a housing complex to pick up a client who is sometimes a little slow leaving the building. Two young men you are sure are drug dealers (you've watched their activities before while you were waiting in front of the building) approach the van and ask you who you are.*

Risk: ___Low ___Moderate ___High

Possible Courses of Action:____

____

____

Standards to guide staff:____

____

____

Situation #3: *You enter a neighborhood that you've been through many times, but today there seem to be a very large number of people on the streets, many of whom seem to have been drinking. You also notice that most of the elderly people and children you usually see in this neighborhood are not on the streets today. The neighborhood seems louder than usual, and there's a sense of something in the air, but you can't exactly identify what it is.*

Risk: ___Low ___Moderate ___High

Possible Courses of Action:____

____

____

Standards to guide staff:____

____

____

Situation #4: *You enter a high-rise building to visit a client who lives on the 11th floor. You discover that only one elevator is working, and that it only goes to the eighth floor.*

Risk: ___Low ___Moderate ___High

Possible Courses of Action:____

____

____

Standards to guide staff:____

____

____

Situation #5: *You have a client who has been involved in a very violent relationship. As she's progressed in treatment, she's spent more and more time talking about her feeling that she needs to get out of this relationship if she's ever going to get into recovery. During the past three weeks, at her request, you've helped her move out of her apartment to a shelter. You've also helped her contact a domestic violence program, which helped her get an order of protection against the paramour. Today the paramour accosted you in the agency parking lot and accused you of poisoning the client's mind. He threatened that if you didn't stop "messing with her," he was going to "teach both of you a lesson."*

Risk: ___Low ___Moderate ___High

Possible Courses of Action:____

____

____

Standards to guide staff:____

____

____

Situation #6: *All week, conflict has been building between two of your clients. The only open seats in the van are two together in back. The first client to be picked up takes one of these seats, and as soon as the second client is picked up, the two start in on each other and the tension rapidly rises.*

Risk: ___Low ___Moderate ___High

Possible Courses of Action:____

____

____

Standards to guide staff:____

____

____

Situation #7: *During a home visit to a client who hasn't been to treatment in a week, you notice that her three-year-old child is heavily bruised, that the house is in a shambles, and that there appears to be no food for either the mother or the child. You tell the client that you're legally and ethically bound to notify DCFS about these conditions.*

Risk: ___Low ___Moderate ___High

Possible Courses of Action:____

____

____

Standards to guide staff:____

____

____

Situation #8: *You're transporting clients from their homes to the treatment center. You remind the last client you pick up to put on her seat belt. She verbally explodes, accusing you of always picking on her while you let the other women get away with murder. She says that you've never liked her and that you'd be happy if she "screwed up" in treatment and couldn't get her baby back. You're taken aback because this client is usually of mellow temperament and you seemed to have had a good relationship with her until now.*

Risk: ___Low ___Moderate ___High

Possible Courses of Action:____

____

____

Standards to guide staff:____

____

____

Assessing and Predicting the Risk of Violence by Clients

Situations sometimes arise in which an outreach worker believes that a client poses a significant threat to another person or persons. When these incidents are brought into supervision, you face difficult clinical, ethical, and legal issues in trying to assess the risk and take steps to reduce the threat. Listed below are some of the risk factors that have been associated with acts of violence against others committed by people with histories of substance abuse. A review of these factors can help you determine the degree of imminent risk. (Note: The same factors can be applied to a paramour or another person in the client's life, to determine the immediate risk from that person.)

___ The client has experienced abandonment, brutalization (severe physical abuse), and horrification (watching others be abused). These acts began early, happened over a long period of time, and/or were perpetrated by more than one person.

___ The client has some history of setting fires, cruelty to animals, and bed-wetting in childhood.

___ The client has a past history of aggressive and violent behavior

___ The client has a substance-related organic disorder that is lowering her level of mental functioning.

___ The client has been diagnosed with, or presents symptoms of, a serious psychiatric illness that is associated with increased risk of violence.

___ The client is currently experiencing paranoia, delusions of persecution and ideas that, if acted out, might result in violence.

___ The client is very immature, has low self-esteem, is very impulsive, and engages in risk-taking behavior.

___ The client is jealous, controlling, and hypersensitive to rejection.

___ The client talks about her fears of "blowing up" or losing control.

___ The client has no social supports, or has social supports that encourage aggression.

___ The client has no personal values strong enough to curb her violent urges.

___ The client has made a specific threat toward an identified person.

___ The client has guns or other weapons, or has access to them.

Source*:* White, W. (1996). *Aggression Severity Index.* Bloomington, IL: Lighthouse Institute.

Critical Incident Debriefing

In some cases the violence that your staff is exposed to in the course of their work might have long-lasting psychological effects on them. These effects can include intrusive memories of the violent event, heightened fear and anxiety, shame about their response to the incident, a tendency to avoid people or things that they associate with the event, and/or psychic numbing.

A critical incident debriefing can help staff work through the effects of a violent incident and avoid sustained psychological effects. The debriefing is a scheduled, structured discussion about a stressful or traumatic event that is outside the range of normal experience. Anyone who was exposed to the traumatic incident has the option to attend. The meeting, which usually lasts no longer than two hours, can be facilitated by an outside trauma specialist or by a supervisor. It's usually held within 24-72 hours after the event. The critical incident debriefing is **not** counseling, nor is it a substitute for counseling.

The format of the critical incident debriefing meeting is as follows:

- Introduction and the explanation of ground-rules
- Cognitive questioning about group members' involvement in the critical incident
- Movement from facts to thoughts and feelings about the event
- A factual reconstruction of what happened. The participants are told:
  Describe what happened from your point of view.
- The experience of emotional catharsis in response to the question:
  What was the most difficult aspect of this situation for you personally?
- The occurrence of "personal sense-making," initiated by the question:
  What thoughts or reactions have you had since the incident?
- The experience of a prediction-and-education phase, introduced by the facilitator's statement:
  These are some things you might experience over the next several days and weeks.
- Closure and linkage to follow-up resources, e.g., an EAP.

If a violent incident occurred today involving one or more of your outreach workers, what resources would be available to you to help conduct a critical incident debriefing of these workers?

____

____

____

Reading Resources:

Friedman, R., Framer, M., and Shearer, D. (1988). Early Response to Posttraumatic Stress. *EAP Digest*, September-October.

Howells, K. And Hollin, C., Eds. (1989). *Clinical Approaches to Violence.* New York: John

Wiley & Sons.

Roth, L. Ed. (1987). *Clinical Treatment of the Violent Person.* New York: Guilford.

Stennett-Brewer, L. (1994). *Violence in the Workplace: Risk Reduction and Management*. Bloomington, IL: Lighthouse Institute.

5.0 Managing the Stress of Outreach Work: Supervisory Strategies

Learning Objectives

1. Identify at least three early warning signs of excessive stress.
2. Identify and define at least five role stressors that lead to stress-related deterioration in professional performance.
3. Identify at least three strategies for managing individual and team stress.

Recognizing Stress-Related Problems in Individuals and Teams

The module on stress management in *Voices of Hope: An Orientation Manual for Outreach Workers* identified personal indicators of stress in five categories: health, excessive behavior, emotional, relationship, and attitude indicators. Drawing from the indicators identified under those five categories, complete the following exercise.

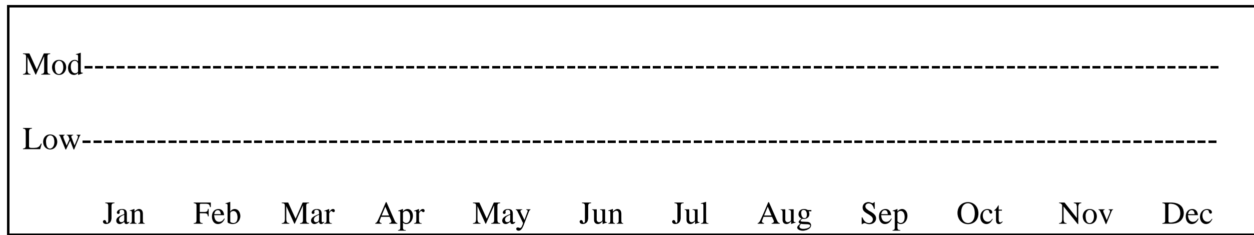
Select two staff members whom you supervise. In the space below, identify indicators that tell you whether each person is at a subtle, moderate, or excessive level of stress.

NAME:	**NAME:**
Subtle Indicators:	Subtle Indicators:
Moderate Indicators:	Moderate Indicators:
Excessive Indicators:	Excessive Indicators:

Team indicators of excessive stress can include frequent tardiness and absenteeism, conflict between individuals or roles within the team, scapegoating of individual staff or units, grievances, staff turnover, client complaints, and decreased quantity and quality of services. On the scale at the top of the following page, draw a line that indicates the levels of stress within your work unit over the past year.

Levels of Stress in the Work Unit

High--



Which team stress indicators (from the previous page) are reflected in the high and low levels that you've plotted?

High ____

____

Low ____

____

A Model for Strategy Development

The diagram below shows the interaction among three factors: role stressors in the work environment, role supports in the work environment, and the individual preferred defense structure (PDS) of an outreach worker.

Role Stressors

Role stressors are conditions in the work environment that simultaneously decrease one's ability to do his or her job, and threaten one's safety and comfort. Role supports are conditions that increase one's ability to do her or his job and increase personal comfort and loyalty toward the organization. The PDS is the unique style of responding to stress and change that each outreach worker has developed over a lifetime.

Listed below are some of the most common role stressors experienced by health and human service workers:

- *Role/Person Mismatch* is the incongruity between an individual's knowledge, skills, and temperament and the kind of knowledge, skills, and temperament required to fulfill the role effectively.
- *Role Conflict* is the experience of contradictory demands from two or more simultaneously held roles.
- *Role/Integrity Conflict* is a conflict between one's personal values and the values encountered in the performance of one's job.
- *Role Ambiguity* is the experience of inadequate knowledge about one's role responsibilities, task priorities, and line of accountability. (What is my job? What tasks are most important? Who do I report to?)
- *Inadequate Role Feedback* is the lack of information on the adequacy of role

performance and methods of improving performance.

- *Role Overload* is caused by excessive and unrealistic expectations regarding the quantity and quality of work to be completed within a particular time-frame.
- *Role Safety Problems* create apprehension about one's physical and psychological safety during the performance of one's job.
- *Role Security Problems* are associated with the experience of uncertainty about one's future role in the agency.
- *Role Connectedness Problems* stem from a worker's isolation from, or overconnectedness to, other members of the organization.
- *Role Deprivation* is the sudden or gradual removal of all significant responsibilities from a worker (retirement on the job).

If your outreach workers were surveyed today, which three role stressors from the above list would they report experiencing most frequently and most intensely? Identify these on the lines below.

1. ____
2. ____
3. ____

Role Supports

Common types of role supports include timeout periods, access to training, supervisory encouragement, peer recognition, time flexibility, pleasant physical conditions, adequate equipment and supplies, and group camaraderie. Review the definition of role supports on the previous page, and list as many supports as you can that now exist in your work environment.

______________________________________ ______________________________________

______________________________________ ______________________________________

______________________________________ ______________________________________

______________________________________ ______________________________________

Responding to Role Stressors

You are the supervisor of a women's treatment unit. Because of a variety of funding cuts and staff turnover, the staff of your unit have been working under a condition of overload for the past four to five months. You have just been informed by your agency director that an accreditation site visit will occur within 90 days and that your unit will receive special scrutiny, since it hasn't been surveyed during previous site visits. Within the next 90 days you must write and implement a number of new policies and procedures, while continuing at your current service level. Meeting this deadline will require some of your therapists' time to write the new policies, and will also place additional responsibilities

on your outreach workers over the next 90 days. You have serious concerns about what this challenge will mean to your already overloaded unit. You also have particular concerns about what these extra demands will do to one of your outreach workers, who already is exhibiting symptoms of excessive stress.

1. What strategies might serve to reduce role stressors (reduce the total amount of work that needs to be performed) during this 90 days?

   ____

   ____

   ____

   ____

2. What strategies might serve to increase supports for your unit during this 90 days?

   ____

   ____

   ____

3. Describe what you would consider the ideal leadership style for this 90 days?

   ____

   ____

   ____

   ____

4. What strategies might be used to support the physical and emotional health of the team as a whole, and of the particularly vulnerable outreach worker, during this 90 days?

   ____

   ____

   ____

   ____

5. The work was successfully completed and the site visit went very well. Describe how you would handle the two to three weeks following the site visit.

   ____

   ____

   ____

   ____

This exercise reinforces three basic strategies that supervisors have used in managing work unit stress:

1. The supervisors can diagnose the unique stressors experienced by a worker or a team, then manipulate the environment to reduce these conditions to the greatest extent possible. Many role stressors will be caused by factors outside the work unit and not be in the immediate control of the supervisor.
2. The supervisor can examine the existing supports experienced by a worker or a team, then manipulate the environment to increase supports that help the worker or the team sustain themselves in the face of those stressors. It is usually easier to increase role supports than it is to eliminate role stressors.
3. The supervisor can intervene programmatically (e.g., by implementing an employee assistance program) or individually (e.g., by providing personal support to a worker) in order to support the strength and flexibility of each worker's PDS.

General Strategies for Managing Individual/Team Stress

In the space below, describe some strategies for managing stress within your work unit in general, and for your outreach workers in particular.

1.____

2.____

3.____

4.____

5.____

Here are some of the approaches that other supervisors have used to manage the stress experienced by outreach workers:

- Flexible use of mental health days (both formal and informal)
- Reinforcing realistic expectations for treatment outcome by defining expectations in small, discrete units for each client
- Teaming for the most difficult home visits
- Using training as a reward and a time-out period
- Brief team meetings at the beginning of the day to organize the day, and at the end of day for emotional debriefing
- Impromptu supervisory sessions when it appears that an outreach worker is having difficulty
- Arranging for recognition of outreach workers by program/agency directors or by funding agencies
- Periodic retreats where staff can step back and critique program operations and reconnect

personally as a team

- Using outside clinical consultants to help process the most difficult situations being faced
- Using supervision to identify the kinds of environmental (agency/inter-agency) obstacles that get in the way of effective outreach services
- Acknowledging the work of outreach workers, both verbally and in written commendations to be placed in their personnel files

Reading Resources

Albrecht, K. (1979). *Stress and the Manager.* Englewood Cliffs, NJ: Prentice-Hall.

Warshaw, L. (1979). *Managing Stress.* Reading, MA: Addison-Wesley Publishing.

White, W. (1986). *Incest in the Organizational Family: The Ecology of Burnout in Closed Systems.* Bloomington, IL: Lighthouse Institute.

6.0 A Final Note

Notwithstanding the knowledge and skills which outreach workers and their supervisors have gained over the past decade, we are all still learning, and, hopefully, continuing to acquire and practice new methods of using outreach services to reach high-risk, treatment-resistent women. Neither the authors of this manual, the Illinois Department of Human Services, Office of Alcoholism and Substance Abuse (the Illinois Department of Alcoholism and Substance Abuse when this manual was written) , nor the many others who have contributed to the completion of this work pretend to have “all the answers” when it comes to providing and supervising outreach services. As time goes on, some of the skills and practices described within these pages will undoubtedly change or undergo modification. Comments concerning the material in this manual are both welcome and encouraged.