Family TO Family

TOOLS FOR Rebuilding Foster Care

Working with Drug-Affected Families

Training for Child Welfare Workers

THE CHALLENGE OF DRUG ABUSE IN CHILD WELFARE, PART TWO

Background

The ***Family to Family*** Initiative was designed in 1992 by the Annie E. Casey Foundation. The framework for the Initiative is grounded in the belief that reforms in family foster care must be focused on a more family-centered approach that is: (1) responsive to the individualized needs of children and their families, (2) rooted in the child s community or neighborhood, (3) sensitive to cultural differences, and (4) able to serve many of the children now placed in group homes and institutions. The Initiative has the following system goals:

- ❒ To develop a network of family foster care that is more neighborhood-based, culturally sensitive, and located primarily in the communities in which the children live;
- ❒ To assure that scarce family foster home resources are provided to all those children (but to only those children) who in fact must be removed from their homes;
- ❒ To reduce reliance on institutional or congregate care by meeting the needs of many more of the children currently in those settings through family foster care;
- ❒ To increase the number and quality of foster families;
- ❒ To reunify children with their families as soon as that can safely be accomplished based on the family s and children s needs not simply the system s time frames;
- ❒ To reduce the lengths of stay of children in out-of-home care; and
- ❒ To decrease the overall number of children coming into out-of-home care.

As a result of the experience in ***Family to Family*** sites, a variety of practical tools has been developed. This booklet describes one such tool Working with Drug-Affected Families.

Why *Family to Family* Became Involved in This Issue

Child welfare workers deal increasingly with families that have drug and alcohol problems. Most workers have had little or no training on ways to assess, motivate and intervene with these families. Available training usually involves fairly abstract theories and general approaches to drug abuse. Little of it focuses on hands-on techniques to facilitate change. At the same time, drug treatment programs are too scarce to meet the need, and many people with drug problems refuse to enter treatment. Even when they do, relapse rates are high, for the user often returns to a trying home environment without enough support.

What We Did

The Drug-Affected Families Training is based upon empirical data and wisdom from practice with methods that achieve results among low-income female addicts such as those entering most child welfare systems. Many different approaches will be effective with certain individuals. Information from the *Back From the Brink* paper was developed into a training package of skills that could be useful if traditional models do not seem to be working.

The training involves the Transtheoretical Model of Change, motivational interviewing, and techniques for preventing relapse. A training manual and handouts are available for distribution. Training for trainers is also available.

The philosophy of the training is that people can make amazing changes, especially if we can give them something they did not have before rather than depriving them of what little they already have. We can t tell if a family is hopeless. We also don t need to have all the answers in order to make progress. We are not so different from the families we serve. Most of us have habits we have difficulty controlling that are harmful to us. Most everyone does things that are bad. It is a matter of degree of harm and whether such habits cause harm to others.

The Transtheoretical Model of Change

Two well-known drug treatment researchers, Prochaska and DiClemente, interviewed many people who made major changes on their own, such as quitting smoking or stopping drugs. They learned that people tend to move through stages in their ability to address problems and make the changes they would like. Strategies that will help a person move through the process vary according to the stage the person is in. Movement through the stages is not always linear. People often move back and forth between stages.

The stages of change they identified are:

- ❒ **Pre-contemplation:** The individual has not even considered the prospect of change. The individual is unlikely to perceive a need for change.
- ❒ **Contemplation:** A state of ambivalence. The individual both considers change and rejects it.
- ❒ **Preparation:** The individual is ready to change.
- ❒ **Action:** The individual engages in actions intended to bring about change.
- ❒ **Maintenance:** The individual identifies and implements strategies to maintain progress.

The most effective responses of workers will depend upon the stage of change of the family member. Motivational interviewing is the strategy most likely to help facilitate movement through the stages of change.

Motivational Interviewing

We usually think of motivation as something someone has or doesn t have. We also discuss motivation in terms of our own values about a person s actions. We might say she isn t motivated because she isn t willing to enter drug treatment. But she very well

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might be motivated to stay with her kids, or with her lover, or to keep her housing and her child support.

In other words, at least two issues mix in our minds when we talk about whether people are motivated: Are they doing things that might lead toward change? Is that behavior directed toward a change we think is desirable?

As workers, what we really want is for people to be motivated to go in the direction we think is best   to take good care of their kids, be clean and sober, and to stay out of trouble, for example. What we often find, though, is that people often don t seem to be motivated at all, they are confused, and they lack skills.

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Rather than seeing people as either having motivation toward positive change or not having it, we prefer to talk about a continuum of motivation. For example, motivation can range from unacceptable behavior, to being resistant, to being nice, but no change, to being highly motivated.

So how do we motivate people? We can look at this question from four perspectives:

- ❒ When people are doing things that jeopardize their kids, we have to set limits to prevent those things. If people are being hurt, or we believe they are about to be hurt, we can t afford to wait and see. It doesn t matter if the person is on drugs or not. Somebody is at risk, and we need to intervene.
- ❒ If people are hopeless, helpless, depressed, and overwhelmed, they are unlikely to make the changes we want them to make on their own.
- ❒ We can help people clean the house, get food, get a job, get the car moving; we can offer to return their children to them if they enter treatment. Sometimes these positive incentives can help a lot in making people feel less overwhelmed and more certain that change is possible. Successes can encourage them and raise their energy levels. They may eventually feel strong enough to tackle their drug problems.
- ❒ It is also possible to help people motivate themselves from the **inside.** We can help people get in touch with their own motives, clarify what is important to them and what they have to work with, and where they want to go. The problem with motivation by either punishment or strong encouragement is that the motivation comes from outside the person. When the outside force is gone, the motivation is often gone too. If we are not there encouraging or threatening, the person can easily slide back into the old pattern.

When we enhance motivation, we help the people (and ourselves) understand what is happening to them, what they believe, and what they want. We can use tools such as reflective listening and self-assessment to help this understanding along.

Our responses to what people say can help them focus a little more clearly on what we want them to do, and may help to encourage them to take one direction over another. We can do this by using more complex reflective-listening skills and providing information about risks or consequences of their behavior.

Pre-contemplation. When the family member is in the pre-contemplation stage, the individual has not even considered the prospect of change. The individual is unlikely to perceive
a need for change. It is usually someone **else** who perceives a problem. At this stage, a person is not likely to respond positively to a worker who is confrontational or demands change.

In the pre-contemplation stage, the worker s main tasks are to engage the person, increase his or her belief that change is possible, address safety concerns, provide needed services in areas besides alcohol and drugs, affirm the individual s strengths and capacity to the point he or she feels competent to change if he or she wishes to do so, and to raise awareness of the problem.

The motivational strategies most effective at this time are meeting concrete needs, developing a positive relationship with the individual, listening reflectively as a response to resistance, and helping the individual with a self-assessment process.

Workers will encounter resistance in the pre-contemplation stage. What is needed here is flexible thinking and responses. The good news is that we receive immediate feedback from the use of our strategies. If the person s resistance decreases, the strategy was effective. If not, it is time to shift strategies.

In general, resistance will be overcome most effectively by avoiding argument. Defending breeds defensiveness. Resistance is a signal to change strategies. Labeling is unnecessary.

Contemplation. When a client is in the contemplation stage, he or she has some awareness of the problem. This is a state of ambivalence, where the individual both considers change and rejects it. If allowed to talk about it, the person goes back and forth about the need to change.

The worker s role is to help tip the balance in favor of change, to evoke reasons to change and the risks of not changing, and to continue to strengthen the family member s sense of self-efficacy for change. The worker strategically uses open-ended questions, affirmations, reflective listening, and summarizing. The worker has the family member give voice to the problem and to his or her concern and intention to change. This is also a time for self-assessment of values, strengths and needs. These tasks fall under the clarification category of motivation.

Increasing awareness of what is going on with the family member is the main task for the worker. A person-centered approach rather than a confrontational one has been found more effective, especially at this stage. The goal is to help people find a private motivation for change, not to push them into it before they believe they are ready. Asking open-ended questions to elicit self-motivational statements (such as, What makes you believe you need to change?) helps people state the problem themselves, which is more powerful than if the worker states the problem.

Helping people discover what they want through a goal-setting process, where they make the choices, increases awareness for both the worker and the people being helped.

This is also a time when both values-clarification and visioning exercises can be helpful, and a time to look at the good and bad aspects of continuing to use drugs.

In the **Preparation Stage,** the person is ready to change. This is a window of opportunity when the person has resolved ambivalence enough to look at making change. The worker s role is to help match the person with an acceptable, appropriate, and effective change strategy, facilitate development of a vision for the future, provide

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information on all available options, explore those options and the benefits and consequences of each, help the person set specific goals and develop a plan, help the person choose strategies to start with and the resources that are needed, and identify potential barriers to the plan.

Strategies to be used include: affirming existing partnerships; preparing for change; setting realistic expectations; assessing options; deciding among immediate abstinence, reduction of drug use, or staying at the same level; and weighing the pros and cons of the options.

Action. Once clients are in the action stage, they are ready to engage in new behavior to bring about elimination of the drug or alcohol problem. In this phase, workers learn to introduce and practice coping strategies to avoid, change, replace, or change a client s reactions to triggers and conditions leading to use, and to suggest methods, provide support in trying them out, and help evaluate the effectiveness of those methods. Participants learn to keep steps small and incremental, teach skills, access resources for their use, reward small steps of progress, and estimate success.

Maintenance. In the maintenance phase, workers assist the family member to sustain changes accomplished in the previous stage; and help the family member identify and use strategies to develop the skills and sense of self-efficacy necessary to build a new life. Participants learn in training to construct relapse roadmaps, prepare crisis plans for times of likely relapse, review warning signs of possible slip or relapse, and make connections to a support system for this healthier lifestyle.

Workers help the family member review the change process and his or her expectations. They also review coping strategies, progress on goals, strengths, values, overall health and well-being, and family members picture of a new life. Participants learn to it happens, by developing a plan and being prepared to move beyond feeling discouraged, so as to keep trying.

How Do the Tools Fit Together?

If communities are changing their systems and developing new models, they may want to wait to deliver this training to workers after the new approaches are designed, so that examples in the training can be tailored for the models involved. On the other hand, these techniques can be used within all service models as a substitute for arguing and threatening. If a community wants to do only one intervention that will really make a difference for families, this might be the one to try.

How Are the Tools Used?

Drug-Affected Families Training can be delivered to any human services workers. Trainers are available for delivery of the three-day course, and we prefer to train trainers so that communities retain an established training capacity.

What We Learned

It is important to prioritize information when preparing training materials. Drug abuse is such a complex issue that one could easily develop hundreds of pages of relevant information, too much for workers to process without becoming overwhelmed. We also learned that we had to choose between giving information and transmitting actual skills in the form of new behavior for workers. Most workers want to know what to do, more than they want to understand all the issues surrounding drug abuse and treatment. Training trainers to deliver this workshop takes more time than many types of trainings. Many role-playing demonstrations are included, and trainers should be able to use the skills well in order to demonstrate them and coach others.

What Is Needed to Begin

To begin, communities need to assess which groups of workers and individuals would be most interested in learning the new skills. The first step would be to schedule a workshop for no more than 25 people, have them assess the training for its relevance to their setting, and proceed on their recommendations.

What Is Needed for Full Implementation

Full implementation involves training of all front-line child welfare workers and their supervisors. Trainers should be trained in order to institutionalize the training capacity.

How to Find Out More: Resources, Examples, References

Resource people include Jill Kinney 253.927.7547, Kathy Strand 253.627.3533, David Haapala 253.925.1883 and Doug Vaughn 541.744.7119. Reference books include *Changing for Good*, by Prochaska, Norcross and DiClemente (1994); *Motivational Interviewing*, by William Miller and Steven Rollnick (1991); and *Relapse Prevention*, by Alan Marlatt and Judith Gordon (1985).