6-2019

PERSPECTIVES FROM SOCIAL WORKERS ON THE ABILITY TO MAINTAIN SOBRIETY AFTER BEING SUCCESSFULLY DISCHARGED FROM A RESIDENTIAL TREATMENT PROGRAM

Samantha Navarro

PERSPECTIVES FROM SOCIAL WORKERS ON THE ABILITY TO MAINTAIN SOBRIETY AFTER BEING SUCCESSFULLY DISCHARGED FROM A RESIDENTIAL TREATMENT PROGRAM

A Project

Presented to the

Faculty of

California State University,

San Bernardino

In Partial Fulfillment

of the Requirements for the Degree

Master of Social Work

---

by

Samantha Ashley Navarro

June 2019

PERSPECTIVES FROM SOCIAL WORKERS ON THE ABILITY TO MAINTAIN SOBRIETY AFTER BEING SUCCESSFULLY DISCHARGED FROM A RESIDENTIAL TREATMENT PROGRAM

A Project

Presented to the

Faculty of

California State University,

San Bernardino

---

by

Samantha Ashley Navarro

June 2019

Approved by:

Janet Chang, Faculty Supervisor, Social Work

Janet Chang, M.S.W. Research Coordinator

ABSTRACT

The research focus for this study was to examine the perspectives of social workers on clients' ability to maintain sobriety. The primary question that was addressed is if social workers believe that a person can continue to maintain sobriety after treatment. The secondary question was whether having a dual diagnosis affects these beliefs. The sampling strategy that was used was the maximum variation sampling, and qualitative data gathering was used for this study through face-to-face interviews between the researcher and the social workers on an individual basis. Each interview was audio-recorded on a digital device. There are a total of eight participants in the study. The study found that there existed a strong connection between maintaining sobriety and having a healthy support system. The study also revealed that professional burnout had a significant effect on the treatment of the client. Finally, the findings of the study point to the importance of psychotherapy in treatment of chemically dependent patients. Overall results suggest the strong need for healthy support systems to maintain sobriety and the necessity of exploring methods to better prevent professional burnout. Results also imply the need for continued research in the area of substance abuse and how to better promote sobriety within the community.

TABLE OF CONTENTS

CHAPTER ONE

ASSESSMENT

Introduction

This chapter describes the research focus for this study and gives a better understanding of the research topic. An explanation of the paradigm is given, as well as a literature review. This chapter also covers the theoretical orientation along with how this research contributes to the social work practice. Chapter one closes with a summary of what was discussed.

Research Focus

The research focus for this study is learning the perspectives of social workers on clients' ability to maintain sobriety after successfully being discharged from a residential treatment program. Maintaining sobriety is defined as continuous abstinence of the substance of choice. A residential facility is defined as a live-in center where patients are provided 24-hour care including housing, meals, and hygienic necessities. In addition to this, they are provided with group therapy, individual therapy, family therapy, meditation, off-site activities, cognitive behavior therapy, and other types of behavioral health resources. The ability to maintain sobriety may be affected as early as the treatment phase itself. In this study, social workers were interviewed within the San Bernardino County area and were asked questions concerning both single- and dual- diagnosis patients.

The primary question that was addressed was if social workers believe that a person can continue to maintain sobriety after treatment. The secondary question was whether having a dual diagnosis affected these beliefs.

Paradigm and Rationale for Chosen Paradigm

A post positivism paradigm was used for this study, which is the most useful in this type of research because it begins with a specific topic or focus while also allowing for flexibility and evolution as the study progresses. One of the assumptions of this paradigm is that qualitative data must be captured in a natural setting. Further, the researcher can never completely step out of the study, and must be aware of their own biases. This paradigm best suits this study because it acknowledges that although the researcher will never be completely objective, they will continuously strive for objectivity. When studying chemical dependency, objectivity is key in order to fully attempt to comprehend the human experience of addiction and those who work with addicts.

Based on their professional experiences, social workers were asked their opinions on the ability of their clients to maintain sobriety. Qualitative research is preferred in such a situation since there is no set hypothesis to be tested. Further, the focus is on the particular words and language used as opposed to any singular data set.

Literature Review

Substance abuse is an illness that affects more than just the primary sufferer. Addiction not only affects the addict, but also surrounding family members, children, and the community. Maintaining sobriety is one of the most difficult things to do for substance abusers after discharging from a treatment facility. There are many factors that can affect their ability to maintain sobriety- such as the clinicians, the treatment facility, and the treatment itself.

This literature review will give an overview of the factors that affect chemical dependency. This includes some possible reasons that could lead a person to engage in substance abuse, interventions that can be used, factors that affect sobriety maintenance, and some prevention strategies.

Causes

There are many factors to consider when thinking about the causes of substance abuse. Many times it is assumed that it is the fault of the addict, but macro issues like poverty and homelessness, as well as micro issues such as childhood trauma and an individual's culture, can play an important role in the development of addiction.

Macro Issues: Poverty and Homelessness. What is often overlooked or not considered is how frequently macro factors can play a major role in chemical dependency. Poverty and homelessness are two of these factors (Blume, 2016; Flanagan & Briggs, 2016).

Many unfortunate people who struggle with substance abuse live in poverty-stricken communities where resources are limited, and it is difficult to find funding to provide the types of activities that would help promote sobriety. For example, something as simple as social recognition within the addict's community can help promote health and reinforce the behavior of sobriety (Siporin & Baron, 2012). Siporin and Baron agree that, "Altering lifestyle to incorporate pleasurable non drug activities is then a plausible means to reduce or eliminate addictive behavior" (p. 105). However, if a person is within poverty limits, the likelihood of those non-drug activities being accessible and affordable are slim.

Another significant factor in the continuing the cycle of homelessness and drug abuse for the homeless population can be the difficulty in finding psychiatric and medical care. Flanagan and Briggs (2016) noted, "Drug abuse is both a symptom and a cause of homelessness that generally hinders persons from making positive change in their lives" (p. 90). Living on the streets often results in both emotional and physical distress stemming from not having adequate shelter, access to healthcare, and nutritious food. This, in turn, can cause a person to self-medicate with drugs, in order to either cope with the psychological troubles or to help ease the consequent physical pain.

Childhood Trauma. When a child experiences a type of trauma, and does not get a chance to fully work through the emotional aspects of it, there is a likelihood this could carry out into their adulthood and manifest in many different

ways. One of those paths can lead to substance abuse (Flanagan & Briggs; Koehn, O'Neill, & Sherry, 2012). These traumas could be abuse (sexual, physical, or emotional), domestic violence, significant loss of life of a loved one, or many more. Whatever the traumatic experience may be, it can lead a person into a feeling of hopelessness with their family, with society, or with humanity. Once a person loses their hope, they may turn to drugs to numb these feelings or avoid facing their past traumatic experiences, leading to addiction.

Cultural Factors. Within the midst of these possible causes, it is important to remember there are cultural factors as well. Every culture has their own perspectives and world views on mental health. Some cultures, such as the Latino/a community, are less likely to seek mental health services (Goldbach, Thompson, & Holleran Steiker, 2011). Acculturation along with other factors such as family pride and cohesion could affect this as well, although Goldbach et al. (2011) found that "familismo" served as a protective factor against adolescent substance abuse. They describe familismo as a type of family connectedness which is more prominent in the Latino/a communities. Additionally, Gill, Wagner and Tubman (2004) agreed that acculturation and ethnic pride can be a major factor contributing to substance abuse, but also added that discrimination, stereotypes and cultural mistrust are major cultural factors as well.

Interventions

Once underlying causes have been identified, they can be used to determine the best type of intervention for the individual. These vary in scope and focus.

Twelve-Step Recovery. Alcoholics Anonymous (AA) is one of the more popular choices for an aftercare treatment plan. Within that group, the 12-step recovery program is usually used. The American Addiction Center Resource (2018) define the 12-step program as teaching its members “how to tackle the problems caused by their addiction, how to make amends, and how to continue in their new lives as recovering drinkers” (para. 3). A study by Brownsamhsa et al. (2007) showed that the12-step recovery program had an abstinence success rate of 64%. This program can help its members understand the meaning behind their drug use as opposed to just “numbing it” (Flanagan & Briggs, 2016). Clients who use AA after discharge have almost twice the abstinence rate compared to clients who do not attend AA (Kaskutas, 2009).

Hope-Focused Interventions. Hope is a characteristic trait that is in most people. It is what helps drive the motivation to continually progress and move forward, and do better or more in their lives. As mentioned earlier, loss of hope could be a contributing factor leading to substance abuse. Therefore, according to Koehn et al. (2012), it is the job of a clinician to continually instill hope in clients, even when all others may have lost it. This is called hope-focused intervention (HFI). Sometimes during recovery, people need to experience

something called “symbolic love”, in order for them to make the conscious decision to abstain from a substance. Flanagan and Briggs (2016) explained that symbolic love is support where “a profound empathy, connection, trust and lowering of stress” (p.96) is given from one person to another. HFI stems from a relatively new area of psychology known as positive psychology, and advocates that clinicians working with the chemical dependent population must continuously have a reservoir of hope, and instill that hope to their clients. The curriculum of HFI has three basic steps: 1) Identify the hope in the client’s life; 2) Make it visual; and 3) Transform unhealthy coping strategies into the goal of feeling hope (Koehn et al.).

Brief Intervention Model. Brief interventions are designed to help educate addicts on the risk involved in substance use and how that risk can be reduced or eliminated completely from the user’s life. The Substance Abuse and Mental Health Services Association (2011) notes that, “Brief interventions are evidence-based practices design to motivate individuals at risk of substance abuse and related health problems to change their behavior” (para. 1).

Brief interventions help aid clients in motivation for change (Flanagan & Briggs, 2016), and is mostly used in individual therapy with substance abusers (Baldwin, Johnson, Gotz, Wayment, & Elwell, 2006). Another intervention that stems from the brief intervention model is called “familias unidas”, where treatment is geared towards 12-17 year olds within the Latino/a community (Goldbach et al., 2011).

Combination of Interventions. It appears that most interventions to treat substance abuse use a combination of treatment modalities. For example, the brief intervention model was used in combination with families eating at least five meals a week together and having open conversations about substances with their adolescents during those meals (Skeer et al., 2016).

A program at an outpatient treatment hospital in New York City used the non-drug social and recreational activities in combination with contingency management programs (Siporin & Baron, 2012). This treatment plan uses positive reinforcement for negative toxicologies, where its participants are rewarded with vouchers for sober recreational activities. This helps in altering the perspective of a recovering addict to see there are other ways to gain happiness in their lives than substance use.

The last combination therapy noted is a brief motivational cognitive behavioral therapy combined with guided self-change. This model is used in the Alcohol Treatment Targeting Adolescents in Need (ATTAIN) program. A clinical trial to evaluate ATTAIN's effectiveness showed significant reductions in alcohol and marijuana use (Gil et al., 2004).

Cultural Modifications. Many communities are beginning to recognize different cultural traditions and beliefs, and are trying to become more educated in cultural awareness. Hospitals often ask their patients what their preferred religious and/or spiritual beliefs are, as well as mental health clinics training their staff to be more culturally competent. Goldbach et al., (2011) note that clinicians

need to have “a firm understanding of the family system in which [they] operate” (p.10). It is important to remember that providing therapy, even for the chemically dependent population, needs to have an element of cultural modification (Goldbach et al.).

How a clinician approaches a client or designs their treatment plan cannot be exactly the same for every client, but rather must be varied based on the clients’ core values and beliefs. For example, the minority community, specifically the Latino/a culture, believes strongly in family, therefore the treatment for someone within that culture would benefit from an intervention such as familias unidas, where the facilitator is bilingual and bicultural (Goldbach et al.). This type of intervention is helpful in educating parents of at-risk youth in methods to promote the child’s academic achievement, increase the effectiveness of parental instruments, and improve the adolescent/parent communication which many Latino/a families have difficulty with.

Factors Affecting Sobriety Maintenance

With the goal being long-term sobriety, it is also important to consider the many factors that can determine whether or not a patient’s treatment is effective, such as the treatment facility, sufficient aftercare planning, the clinician’s involvement, and social worker burnout.

Treatment Facility. While a patient is in a treatment facility, they are learning the tools and skills needed to maintain sobriety after discharging or

graduation. Some factors that can affect their treatment from within the facility itself include staffing, aftercare planning, and house rules.

High turnover rates within the facility have been shown to have a major impact on treatment received. Patients are more likely to feel disengaged when staff are consistently changing or limited because they have to repeat their story over again and they have to rebuild the rapport and trust (Baird, Campanaro, Eisele, Hall, & Wright, 2014). Many times during treatment patients need stability and structure, but having constant changes causes a lack of continuity of care, which in turn affects the readiness the patient will have when it is time to discharge. High turnover rates also can be financially draining to the organization itself (Baldwin et al., 2006), because they have to spend money on the resources to recruit and train new staff. With more spending on training, that leaves less funds available to provide resources and activities for the patients.

Aftercare Planning. Another central factor in sobriety maintenance is the aftercare planning for the patient. Many times it is difficult for the patients to acclimate to mainstream life when they were on strict treatment schedules. Baird et al. (2014) note that once a patient leaves the treatment program, it is vital to have structures within the community to provide continued support. They also suggest that lack of communication between the staff members and the outside resources can negatively affecting the aftercare plan, and that some patients felt as if more collaboration between treatment staff would benefit the outcome of both their treatment and subsequent discharge planning (Baird et al.).

Finally, prohibiting tobacco use during treatment may help boost sobriety maintenance. A study by Stuyt (2014) showed that patients who did not abstain from tobacco were more likely to relapse after discharge. Therefore a patient may be more likely to maintain sobriety after discharging from the treatment facility, if the facility could implement a no tobacco rule.

Clinicians. The clinician plays a vital role in a patient's life, especially for providing coping skills and tools needed upon discharge. This is why it is important to have a good therapeutic relationship with the client, also called the "therapist/client working alliance" (Blume, 2016). Along with a strong therapeutic relationship, the clinician must also have positive feelings about the organization or program that they are working for, which raises the likelihood of the patient having positive outcomes after treatment (Blume).

One component of having a good clinical relationship is having cultural competence (Goldbach et al., 2011), which can help clinicians better understand their clients' individual stressors and identify what their strengths are. Culturally incompetent clinicians may negatively affect both the clients and their communication together. As discussed earlier, patients feel that communication is essential during treatment in order to have the best discharge outcomes (Baird et al.), thus improving it is vital to a successful recovery.

Burnout. Most graduate-level studies stress that self-care of the clinician is very important and the major factor in preventing burnout. Burnout can be caused due to low pay, lack of prestige in their work, and having an

overwhelming caseload causing the clinician to have more interpersonal conflicts, being less effective, and showing low productivity (Oser, Biebel, Pullen & Harp, 2013). Many studies agree that professional burnout can have negative implications on the attitudes of clinicians (Bakker & Costa, 2014; Oser et al., 2013; Rupert, Miller & Dorociak, 2015; Servais & Saunders, 2007), and cause them to have a lower quality of life (Oser et al.; Rupert et al., 2015).

Working with the dual-diagnosis population may cause higher rates of burnout due to this population generally having more social problems such as employment issues, minimal social support, and lack of housing (Oser et al.). Sometimes dual-diagnosis patients are segregated from the single-diagnosis patients because of the difficulty level, and are thus less likely to participate in treatment to begin with (Siporin & Baron, 2012). Therefore, it is important to be aware of which population is being worked with, so the clinician can avoid or prevent the risk of burnout.

When a clinician does experience burnout, they often have high levels of stress paired with feelings of low personal accomplishment. Clinicians who are experiencing burnout could have more negative attitudes towards the clients they are working with (Oser et al.; Servais & Saunders). Oser et al. noted one participant explaining that burnout affects him by wondering if the work he does even makes a difference in the clients' lives. It can be assumed that if a clinician has negative attitudes towards their client's success, the clinician may not then be fully invested in the treatment process.

Because of such factors, clinicians should be trained in ways to prevent burnout and the importance of self-care and having co-worker support should be stressed (Oser et al.). Van Dernoot Lipsky (2015) explained that self-care is a necessity and described how burnout tends to grow gradually. With this gradual development, many times a clinician does not notice they are experiencing burnout until it has significantly progressed. In addition, all staff that work with the substance abuse population should be trained in addiction, the type of drugs that are abused, as well as the legally prescribed drugs that are abused (Baldwin et al., 2006). With all staff on the same page, it may help the patient to have continuity of care.

Prevention

Prevention is an important aspect of reducing the amount of people who are chemically dependent, and early intervention, proper education, and a consideration of culture play key roles.

Beginning in Childhood.

As Skeer et al. (2016), explained, the brief intervention model can be used in combination with frequent family meals and communication to aid not only in treating substance abuse, but also in preventing it. If parents are actively communicating with their children on substances and increasing the amount of family time spent, this could help aid in a decrease of adolescent substance abuse.

Education.

In order to help prevent adolescent substance abuse, it is important to have strong family connections and communication. Blume (2016)

notes that “prevention programs that focus on the family rather than on the individuals have been successful” (p. 50).First, it is important to help parents develop effective methods of improving the communicative relationship with their children. Secondly, parents must learn how to teach their children the strategies that will enable them to both avoid situations where there will be substance use, and to decline offers of substances if they find themselves in such a situation. This training could include skills such as drink refusal tactics, and could significantly reduce the chances of adolescent substance abuse (Blume).

Culture. As discussed earlier, clinicians should be aware of their patient’s culture. Culture could be used to the clinician’s advantage during the treatment stage (Gil et al., 2004). In the Latino/a culture, “familismo” serves as a protective factor in preventing adolescent substance abuse (Goldbach et al., 2011), which will lead them down a path to a healthy adulthood as opposed to being chemically dependent. To help prevent people from becoming addicts, more outreach programs could be developed that are culturally competent and aim towards reducing and preventing stereotypes and discrimination.

Conclusion

It appears that there are many factors that could hinder a person’s attempts to maintain sobriety after completing a treatment program, including macro issues, past trauma, and cultural incompetence. The literature also suggests there are many successful interventions that can be used such as AA, a12-step recovery program, hope-focused interventions, a combination of

interventions, and the brief intervention model. However, the best option for substance abuse is to stop it from happening in the first place. This can be done with prevention strategies that parents can implement within their own families, organizations that provide education for both parents and clinicians, and a strong sense of what burnout is and how it should be prevented.

Theoretical Orientation

The paradigm chosen for this research topic is post positivism. With the post positivism paradigm, research assumes objectivity therefore it is important to be aware of the theories relevant to the study in case they need to be included later. It is possible that some clinicians may have professional bias caused by burnout (Servais & Saunders, 2007). Burnout is a syndrome where one is in a state of emotional exhaustion “described as feelings of being emotionally drained by one’s work” (Bakker & Costa, 2014, p. 113). With that being said, the job demands-resource model from resources theory (Rupert et al., 2015) would be the preferred theoretical orientation for this study. This model helps explain the development of burnout, which may contribute to the perspectives of a clinician and the outcome of their patients’ success. More specifically related to chemical dependency, this theory allows for further discussion on how social workers’ opinions on the ability to maintain sobriety may affect the treatment and recovery outcomes of the clients they work with.

Contribution of Study to Micro and Macro Social Work Practice

Learning more about clinicians' perspectives of both single- and dual-diagnosis patients will contribute to both the micro and macro social work practice. A few of the contributions it would make is to understand how single- and dual-diagnosis patients receive treatment, help clinicians better utilize resources to help clients maintain sobriety, and determine whether social workers' personal opinions on attaining permanent sobriety can affect how they work with the clients.

On a micro level, by clinicians more fully understanding the effects chemical dependency has on a client's life, they would be able to utilize more successful and specialized tools to both prevent substance abuse and assist in recovery. On a macro level, organizations and future research can be focused on first making sure clinicians who work with this population have positive beliefs in a client's capability at maintaining sobriety as well as implementing policies for clinicians working within this particular population.

Summary

Chapter one explained the focus of this research study as understanding the opinions for successful maintenance of sobriety from the perspective of social workers. This study was conducted in the San Bernardino County with social workers. The paradigm used was the post positivism paradigm. The literature review outlined important aspects in regard to this area of study. The theoretical

orientation used was the advocacy theory. Finally the chapter closed with explanation on how this study will contribute to both macro and micro social work knowledge.

CHAPTER TWO

ENGAGEMENT

Introduction

Chapter two discusses the engagement stage of this study. First details of the study site are provided including where the study site was and the type of services provided, as well as the site gatekeepers. This chapter also covers self-preparation, including diversity issues, ethical issues, and political issues. Finally, the role of technology in regard to this study is discussed.

Research Site

This study required access to social workers at the level of at least an M.S.W. or students in a graduate level M.S.W. program. Multiple agencies were used in a county located in Southern California. According to the United States Census Bureau (2017), this region is made up mostly of minorities, with a population of 52.8% Hispanic or Latino/a; 29.3% White-not Hispanic orLatino/a; and 9.5% Black or African-American. Agencies included outpatient clinics and inpatient residential treatment facilities, in order to capture the diverse opinions of social workers working in various fields. Services offered at these agencies varied from residential treatment, outpatient treatment, individual therapy and group therapy. Group therapy includes cognitive behavioral therapy, anger management, interpersonal process groups, and psychoeducational groups. The

workers who deliver these services vary from drug and addiction counselors, M.S.W.'s, L.C.S.W.'s, and M.S.W. Interns. Clients' characteristics include addiction to alcohol or a substance, impulsivity issues, co-dependency, unhealthy coping skills, and dual-diagnosis. The focused service population was low socioeconomic groups.

Engagement Strategies for Gatekeepers at Research Site

To gain access to the study site, I engaged with the gatekeepers at the site, who were the clinical director and facility manager. I first introduced myself, and explained my role in the study. In order to gain the gate keeper's permission for this study, I explained my purpose and how this study could benefit the agency. I explained that gaining knowledge from the study results could benefit the agency by providing ways to better treat patients in chemical dependency and help agency leadership develop good ideas on how to improve treatment programs. This will also help the social work field to find out more about what the social workers who work closest to this social problem think about sobriety.

Permission to do the study was given from the program manager and the facility manager, after discussing the research process and agreeing with a plan. After gaining approval to conduct the research within that particular agency, a list of all probable participants was compiled in order to connect and discuss the possibility of participating. The purpose of this study was explained, and participation in this study was voluntary. When using a post positivism paradigm,

it is important to gain an understanding of the participants' feelings and perceptions about the study topic and let this guide the study. Thus, I used active listening skills when engaging with gatekeepers and participants.

Self-Preparation

The most important aspect of self-preparation was conducting the literature review as well as speaking to the experts already in the field. Both of these aspects helped me gain knowledge and insight into this research topic as well as increasing my background knowledge of the topic as a whole. By understanding successful ways that a person can maintain sobriety, I developed better insight when discussing the social workers' opinions.

Additionally, research was conducted on each study site used. This is important since each agency has its own philosophy and mission statement, and this could be important to remember when receiving responses from the social workers at that particular agency. To prepare these participants for data gathering, it was important to explain the purpose of the study and to debrief them afterwards.

Diversity Issues

A few diversity issues arose during this study. The first was the differences between genders. This study had more female participants than males. This is

consistent with the United States Department of Labor (2017) that note that women make up approximately 82.5% of social workers.

Additionally, age was a factor as well. Younger participants may have more positive feelings on a clients' success, whereas seasoned participants may feel more negatively or could also be experiencing burnout from practicing in this field for a long period. To address these issues during the study, a strong effort was made to interview male and female as proportionately as possible. Likewise, an attempt was made to interview participants with similar years of experience in the social work field. After gaining the results of this study, recommendations on how to address these issues that may possibly arise will be discussed.

Ethical Issues

One probable ethical issue that arose during the interviewing stage is authenticity. Participants may have responded with answers they felt were ethically correct as social workers, such as consistently supporting and believing in the clients' success. This may vary from what the participant actually feels or practices and can skew the results of the study.

It is important to be mindful of possible HIPAA violations. Therefore each participant signed an informed consent so they understood the purpose of study, their guaranteed confidentiality, and the way their answers will be used and protected. It was important to also verbally explain confidentiality to each participant even though they signed the informed consent.

Before beginning the interview, boundaries were discussed, and more specifically participants were taught the proper way to present client examples while maintaining the client's anonymity. All Interviews were recorded on a digital recorder, then transferred to a computer and transcribed. After being transcribed, the audio recording was completely deleted. No identifying information was recorded such as name, address, and phone number. In addition, the name of the agency was not used.

Political Issues

Another important issue that could have arisen could be that participants may not have answered with full honesty due to feelings of protectiveness towards their agencies. The agency, in turn, may have felt worried about research results showcasing their social workers as unethical or even negatively representing the agency as an entity. It was important to explain to each participant that this study does not reflect the clinicians nor does it judge the agency in any way. In addition, communication with the agencies' leadership explained that the agency and clinicians' real names were not to be used.

The Role of Technology in Engagement

Technology played an important role in the engagement stage. Initially, e-mails were sent to various agencies as the first form of contact to attempt to set

up a meeting with the clinical director or the facility manager. This was then followed up with telephone calls.

Audio recording was necessary to capture all of the verbal information given during the interviewing process, allowing for transcripts to be made. Video recording was not used with this study, since it could have made participants feel more uncomfortable than using purely audio.

Summary

Chapter two covered the engagement stage of this study. The study sites that were chosen were within the San Bernardino County service area, and varied from inpatient residential treatment facilities and outpatient treatment clinics. Engagement with the gatekeepers of these sites was essential, and was specifically with the clinical director and facility manager. I self-prepared by researching further on the topic of the study to gain basic knowledge, as well as researching each agency in order to have a better understanding on every agencies' particular philosophy. Diversity, ethical and political issues were discussed in relation to the study. Chapter two closes with a short discussion on how technology will be playing a role in this study.

CHAPTER THREE

IMPLEMENTATION

Introduction

This chapter explains the implementation stage of this study. The study participants and selection process of the participants are discussed. In addition, data collecting is explained including the phases of data collection and data recording. Finally it ends with the data analysis procedures.

Study Participants

The participants for this study were both male and female students of an M.S.W. program or current social workers, with no restriction on age. They had to possess at least a MSW degree, but were also Licensed Clinical Social Workers (L.C.S.W.) or any higher level degree in the field of social work. The participants were either students enrolled in the MSW program at a Southern California university, or clinicians who worked in a clinic or facility within the San Bernardino County service area. Participants' professional background was expected to be diverse, including direct micro practice with individual, group, family and couple therapy, as well as possible macro practice such as grant writing and legislation involvement. Services provided by these participants included giving individual, couple, marital, family, and group therapy, as well as collaborating with drug and addiction counselors. Participants working within the chemical dependency

specialization were likely providing services such as detox care, case management, treatment plans, discharge planning, and aftercare.

Selection of Participants

The sampling strategy that was used is the maximum variation sampling which takes into account that individual experiences differ (Morris, 2006). This type of sampling strategy best fits with this study because it allows for the recruitment of participants with different backgrounds and experiences. The agency provided a list with possible participants who fit the requirements for this study and the participants were contacted via e-mail and phone.

There was not a set number of participants expected for this study. The sampling was terminated after there were sufficient repetitive answers. They were selected from two different types of agencies: Residential treatment facilities and outpatient clinics. This allowed a variety of different social workers with different professional backgrounds to be included in the study. All participants voluntarily agreed to participate and signed an informed consent. Participation in this study was completely voluntary, therefore no compensation was given to social workers who decided to participate.

Data Gathering

Qualitative data gathering was used for this study. The data collected was gathered through face-to-face interviews between myself and the social workers

on an individual basis. There were preselected questions to be asked during the interview (see Appendix A), however the interview varied based on where the participant took the conversation. To prevent leading the participants into a particular answer, descriptive questions were used. For example, “What factors would help aid a client in maintaining sobriety?”; “How does being single- or dual-diagnosis differ during treatment?” which allowed the participants to simply describe their thoughts on the topic given.

One of the topics covered during the interview was whether there is a difference in answers from social workers who are working or have worked with chemically dependent patients before versus never worked with this population. This was evidenced by asking, “What professional experience do you have providing treatment in chemical dependency?” Another topic covered during the interview were what improvements can be made, both during treatment and with the aftercare planning that can heighten the success rate of sobriety. This was evidenced by asking questions such as “What type of treatment is needed in a residential program to provide quality treatment?” and “What factors do you think would cause a patient to relapse?” The final topic covered during the interview was whether social workers felt that dual-diagnosis and single-diagnosis vary in success rate based on mental diagnosis.

Phases of Data Collection

The data was collected by first interviewing the participants and then analyzing the transcripts from those interviews. The structure of the interviews included the following four stages: Engagement, development of focus, maintaining focus and termination.

The engagement stage began with explaining the purpose of the study, confidentiality, and giving the participant the informed consent. This stage was designed to help the participant feel more comfortable by the researcher introducing themselves as well as ask engaging questions to begin the interview such as, “How long have you been in this field?”

During the interview, the development of focus began when the first interview topic questions of experience versus no experience in chemical dependency was asked. The maintenance of focus continued with questions that built upon the previous question, which led into the proceeding interview topics of options to improve treatment, followed by perspectives of participants of sobriety maintenance after treatment.

Finally, the termination stage of the interview had a wrap-up conversation including thanking the participant for participating in the study as well as giving the participant the debriefing statement.

Data Recording

Each interview was audio-recorded on a digital device. Technical issues that could have arisen were the device not working properly and recording, and fear from participant of confidentiality issues. To resolve these issues, a backup recording device was available in the case that the primary recording device became defective. In regard to confidentiality, it was explained to the patient that after recording the interview on the digital device, it would be transferred to a computer and transcribed. After being transcribed, the digital recording would be permanently deleted.

Data Analysis Procedures

The type of analysis that was used was the “bottom up” analysis. This allows the researcher to look at the data as a whole and find patterns and groupings. The first step was adding the transcribed interview documents into a computerized data analysis system called Atlas-ti. This allows the researcher to begin with open coding, which allows the transcribed interviews to be “chunked” out into sections. These sections were patterns that were similar and themes that were recurring across the participants’ interviews. Expected themes with open coding were perspectives of client success rate, opinions on possible treatment changes, and perspective of difference between single- and dual-diagnosis patients.

After open coding, axial coding was the next stage. Axial coding allows the chunks in the Atlas-ti program to be linked together, which formed patterns. This allows the research to show patterns and relationships between the categories found in open coding. The third stage was selective coding, where major themes were developed.

Summary

Chapter three reviewed the implementation stage of the study. Social workers with an M.S.W. degree or of higher level were the study participants, including participants who were currently students of an M.S.W. graduate program. They were selected from a variety of agencies including residential treatment facilities and outpatient clinics. Type of data gathered were qualitative data by face-to-face interviews. There were two phases of data collection: 1) gathering information from the literature review, and 2) data collecting from the transcribed interviews. Data recording used an audio recorder during interviews, and interviews were transcribed. Chapter three concludes with the data analysis procedure which includes a “bottom up” analysis as well as a computer system called Atlas-ti.

CHAPTER FOUR

EVALUATION

Introduction

Chapter four discusses the evaluation stage of this study. This chapter will cover the analysis of the data which includes the description of demographics of the participants. It will also contain the analysis and interpretation of the data, where major and minor patterns will be identified. Finally, chapter four will identify and discuss the implications of findings for micro and/or macro practice.

Data Analysis

There were eight participants in this study. The majority of participants were female, with nearly 63% female and 37% male. Most participants were 25 years or older, with only 12% of participants between the ages of 18-24. A half of participants (50%) were single, 37.5% married, and 12.5 % divorced. There were only two ethnicities self-identified in this study, with 25% African American and 75% Hispanic. Six participants (75%) were fairly new in the social work field, having 0-5 years of service and two participants reported 16+ years of service. All participants reported having a higher education of at least a Bachelor's degree or higher, with 75% of participants currently students or recent graduates of a MSW program.

When participants were asked about the populations they have experience working with, their answers varied greatly including the areas of children, adults, geriatrics, family, victims of domestic violence, forensics, LGBT, and trauma. Specifically, five of the eight participants have experience working with the chemically dependent population. Only one participant has experience working with sexual trauma.

When participants were asked about their professional experience specifically with the chemical dependent population, nearly all participants' answers were uniform, describing having experience working with inpatient or residential care for chemical dependency. With the exception of one participant, all the other participants disclosed having 1-2 years of experience with inpatient or residential care for chemical dependency. Participant #8 was the only participant who did not have experience with this population, and stated, "I have both an Associates and Bachelors in Psychology and am currently working on my MSW".

When participants were asked their opinion on what is needed for quality residential care for chemically dependent patients, most of the participants emphasized the importance of psychotherapy, to include individual and group therapy as well as family and couples counseling. There were mixed answers across participants about what specifically is more important. Two participants stressed the importance of case management. For example, Participant #1 explained, "Intensive case management is needed" and "it has to be intensive

and it has to be really structured in order for them to get some type of structure in their life". Another two participants specifically mentioned the need for a balance between psychotherapy and a medication regimen, whereas one participant said the most important aspect is to standardize care across the board for all chemically dependent patients. Participant #4 stated, "Like if this is your first time you go here, this is your second time you go here, this is your third time this is the more intense program". On the other hand, one participant emphasized the importance of a good support system. For example, Participant #7 stated, "I don't think that there's any certain particular treatment modality", and instead feels patients need "a good support system and getting them to reconcile some of the frayed relationships". Only one participant believed that empathy is what is important for quality residential care.

When participants were asked what they believed are factors of relapse after a patient completes a residential program, all of the participants with the exception of one expressed the lack of healthy support system as the main factor of relapse. For example, Participant #4 stated, "I think that's huge in that really affects their relapse" and "I would say that it's a higher risk". These same participants also noted other contributing factors such as the patient not exploring triggers, or using their coping skills, not following their aftercare plan, not having job security, not using the proper resources for their community such as AA or other support groups, and not using a sponsor. Most of the participants mentioned patients going back to the same environment as a factor as well. One

participant explained that if a patient goes back to the same neighborhood they were living at prior to entering the program, they will more likely be surrounded by the same negative and non-sober influences, increasing their chance of relapse. For example, Participant #4 said, “I would say that it's a higher risk for people that are going back home” and they are more likely to “just spiral out of control”. However, one participant shifted blame on the residential program. Participant #7 said, “If the residential program has not explored the resident’s trauma and has not come up with a good transitional aftercare plan” they are not doing their job. Additionally, Participant #7 mentioned the importance of “not just treating the disease but treating the individual”.

When participants were asked what would aid a patient in maintaining sobriety, most of the participants expressed the importance of support, both familial and financial, as a strong factor for aiding sobriety. For example, Participant #4 stated the importance of “helping them start, like a brand new life”. Other additional factors mentioned were stability, aftercare planning, housing, sponsors and AA/NA programs. Participant #4 stated, “I think people go back to old habits really easily, but if you work really hard 6 months after you graduate, I think you could have a bigger lasting effect”, whereas Participant #5 said, “that first month is crucial to whether they survive or they fail”. Six of the eight participants expressed the residential programs’ duty to help with these factors and for the social worker to help the patient with these factors both during and after treatment.

When participants were asked if there was a difference with treatment of single- versus dual-diagnosis, participants had very mixed responses. Some participants believed there is no difference in how participants are treated. For example, Participant #3 responded, “I don’t think so. It all depends on getting the right diagnosis.” On the other hand, other participants indicated that there should be a difference in treatments between patients with a single diagnosis and those with dual diagnoses. Participant #2 states, “I think based on what I've seen there is a difference”, but was unable to explain why there was a difference.

There were also mixed responses on beliefs of whether the mental aspect or the drug aspect should be treated first in dual diagnosis patients. Participant #8 suggested that the mental health should be addressed first because, “mental health is often the root of the substance abuse.” Similarly, Participant #4 explained that they believe mental health should be treated first because “most people don’t deal with a mental health issue and the emotions and they try to mask it with drugs.” On the other hand, some participants believed that both mental and drug aspects be treated at the same time. For example, Participant #1 said, “both mental and drug aspects should be treated concurrently.” Furthermore, Participant #7 indicated, “the first step in treatment for dual-diagnosis patients needs to be the detox stage, followed by treatment of both the mental health and the drug use together.”

When participants were asked on their opinions of the success rate of single- versus dual-diagnosis, participants’ responses were varied. Two

participants felt that there was no difference between a single and dual diagnosis. For example, Participant #3 stated, “success was dependent on the right treatment for the diagnosis.” Similarly, Participant #5 said, “success depended on how hard the patient was willing to work towards sobriety. Two other participants felt single diagnoses would have higher success rates. For example, Participant #4 explained, “patients with a dual diagnosis just seem to struggle more with life in general and patients with a single diagnosis seemed like they could see the light at the end of the tunnel a lot better.” Similarly, Participant #6 said, “with single-diagnosed patients their success rate was a lot higher” and blamed it on dual-diagnosed patients dealing with multiple issues. Contrarily, other participants were unable to answer, mostly stating a lack of research on the statistics. Only one participant felt that patients with a dual-diagnosis would have a higher success rate due to being able to address more mental health issues and helping with the coping mechanisms that, in turn, help with the addiction.

When participants were asked whether social workers’ perspectives affected the quality of treatment given, the majority of responses showed a belief that it had a strong impact. Specifically, 6 out of 8 participants stated that there is a high impact of patient success based on the social worker’s perspective, and many noted a need for social workers to pay attention to their biases and transference, as well as having an open mind. For example, Participant #4 explained, “I had to really overcome my own perspective that they were going to

be very difficult and that I was not going to be able to relate to them". Similarly, Participant #5 said, "if you already have your mind made up, it's going to be hard to treat that patient". Participant #8 agreed and stated "their success rate is greatly diminished" if the social worker has a negative perspective. One participant did not specifically answer this question, but did note that it is the duty of the clinical manager of the program to not put employees in case scenarios that are going to cause failure.

When participants were asked what could be done to raise long-term sobriety maintenance, each participant had a different perspective. Some participants continued to stress the importance of social support and having the social worker keep in touch with patient after discharge. Other participants explained a need for society or communities as a whole to change. For example, Participant #4 stated,

> I think society does need to change their perspective of how they view addiction and how they view recovery and communities need to really help these individuals, welcome them and help them look for jobs, make them feel included in the community.

On the other hand, one participant blamed society, and felt that messages are often sent through images on the acceptance of substance use such as with alcohol and marijuana.

There was an additional question about social worker burnout that was presented to half of the participants. All four participants agreed that burnout negatively impacts the treatment given to patients. Participant #4 said,

> Even just for me it was definitely kind of heart-wrenching to see that, you know, you put all your effort and hard work into something and then you hear that, you know, they graduated and then they relapse and it would be hard not to take things personal or to just feel discouraged all the time and to think they are just going to relapse so it doesn't matter anyways.

Participant #5 offered advice on preventing burnout by "not taking the work home" and stated "like the same thing as when you're going to work, you leave your family problems at home". Finally, Participant #1 explained, "If you feel burnout, chances are that you're not giving your all". All four participants who answered this question expressed the importance of self-care, especially working with the population of chemical dependency.

Data Interpretation

One key finding identified in the study was the connection between maintaining sobriety and having a healthy support system. This finding is consistent with Litt, Kadden, Kabela-Cormier and Petry (2009), who found, after doing a two-year follow-up study, that social networks strongly predicted long-term drinking outcomes. Other research agrees that the healthy social support is a strong contributor to sobriety (Baird et al., 2014; Laudet, Harris, Kimball,

Winters, & Moberg, 2016; Siporin & Baron, 2012; Stead & Viders, 1979). This study's finding is also consistent with Polcin and Korcha (2017) who found that people who have drug and substance use in their social networks were at higher risk for social influence.

The second key finding identified in the study is how burnout has a significant effect on the treatment of the patient. This finding is consistent with various studies which found that therapist burnout negatively impacts clients (Bakker & Costa, 2014; Oser et al., 2013; Rupert et al., 2015). It also coincides with a study by Servais and Saunders (2007) that found when psychologists perceive clients negatively, they are more likely to dis-identify or distance themselves from the client.

The third key finding was the importance of psychotherapy in treatment of chemically dependent patients which includes individual and group therapy, cognitive behavioral therapy, and case management. This finding is also consistent with many studies that show the effectiveness of psychotherapy in treating this population (Baldwin et al., 2006; Flanagan & Briggs, 2016; Gil et al., 2004; Goldback et al., 2011; Koehn et al., 2012; Siporin & Baron, 2012).

Implication of Findings for Micro and/or Macro Practice

Based on the findings of this study, results suggest the strong need for healthy support systems to maintain sobriety and the necessity of exploring methods to better prevent professional burnout. Professional burnout negatively

effects the quality of treatment given to a patient. Results also imply the need for continued research in the area of substance abuse and how to better promote sobriety within the community.

The key finding of the link between social support and sobriety is important not only for macro practice but for micro practice as well. For the macro aspect, results suggest that it is vital that communities come together to begin drawing plans on how to change the overall perspectives of substance abuse. In regards to micro practice, results suggest the need for training and assistance for the family members and friends of the patient, as their support will play a major role in the patient's recovery and post-treatment life. It is also important for the family members to have their own therapy, either individually or as a group, to help rebuild frayed relationships.

Finally, social workers, specifically those who work with the chemically dependent population, should be hyperaware of the possibility of burnout, and maintain a proper self-care regimen. Results of this study suggest further research is needed on how to acknowledge burnout and take more preventative measures. Agencies that service the chemically dependent population should enforce policies and procedures to protect the overall health of the social worker in order to properly care for its population.

Summary

Chapter four reviewed the evaluation stage of this study. The data analysis included participant demographics of nearly 63% females and 37% males. The majority of participants (75%) self-identified as Hispanic. There were three key findings of this study. The first finding was the importance of social support in maintaining sobriety. The second finding was how professional burnout negatively impacts the patient's treatment. The third finding noted the importance of psychotherapy which includes individual and group therapy, cognitive behavioral therapy, and case management. The implications of the findings suggest the need for further research on the effects of professional burnout on a patient's treatment. Results also suggest the need for development of a training program for friends and family of chemically dependent patients. Finally, results indicate an importance for these training programs to include some type of individual or family therapy to rebuild frayed relationships. This study implies the importance of professional burnout prevention and need for self-care.

CHAPTER FIVE

TERMINATION AND FOLLOW-UP

Introduction

Chapter five discusses the termination and follow-up of this study, the communication of findings to the study site and study participants, and will explain any ongoing relationship with study participants. Finally, Chapter five will conclude with a detailed explanation of the dissemination plan.

Termination of Study

The termination stage was fairly easy, and consisted of simply thanking the participants for their time. Each participant was handed a one-page debriefing statement. This statement explained what the study was about, and what I was attempting to assess. The debriefing statement included the primary and secondary questions of the study: 1) the perspectives of social workers on sobriety maintenance and how this may affect the treatment given, and 2) whether social workers have different perspectives for single diagnoses and dual diagnoses recovery success rates.

Communication of Findings to Study Site and Study Participants

The final research report was submitted to California State University, San Bernardino. Participants were invited to review findings through the university.

The follow-up for the study site and participants included an invitation to a meeting where they would be provided verbal in-person communication presenting the results of the study.

Ongoing Relationship with Study Participants

All ongoing relationships with study participants have been completely disengaged with the exception of one participant. Although not ideal to have an ongoing relationship with any of the participants, that participant currently works at the same agency as me. This particular participant took part in the study voluntarily without incentive, prior to beginning at this agency. Their participation in the study was in no way related to current status at the agency.

Dissemination Plan

The dissemination of research findings was done with a poster board and presented on June 11, 2019 at California State University, San Bernardino. This poster board included a chart of the demographics of study participants as well as key findings. Key findings of the study included: 1)the importance of social support in maintaining sobriety, 2) the negative effects of professional burnout, and 3) the importance of psychotherapy which includes individual and group therapy, cognitive behavioral therapy, and case management.

APPENDIX A

DATA COLLECTION INSTRUMENTS

CALIFORNIA STATE UNIVERSITY
SAN BERNARDINO

College of Social and Behavioral Sciences
School of Social Work

INFORMED CONSENT

The study in which you are asked to participate is designed to examine social workers' perspectives on a clients' ability to maintain sobriety from social workers within the San Bernardino County. The study is being conducted by Samantha Navarro, a MSW student under the supervision of Dr. Janet Chang, professor in the School of Social Work, California State University, San Bernardino. The study has been approved by the Institutional Review Board Social Work Sub-Committee, California State University, San Bernardino.

PURPOSE: The purpose of the study is to examine the perspectives of social workers on a clients' ability to maintain sobriety after graduating from a residential treatment program.

DESCRIPTION: Participants will be interviewed and asked a few questions on ability for a client to maintain sobriety, what factors affect sobriety and relapse, the difference of success rate between single diagnosis and dual diagnosis and some demographics.

PARTICIPATION: Your participation in the study is totally voluntary. You can refuse to participate in the study or discontinue your participation at any time without any consequences.

CONFIDENTIALITY OR ANONYMITY: Your responses will remain confidential and data will be reported in group form only.

DURATION: It will take 30 to 40 minutes to complete the interview.

RISKS: There are no foreseeable risks to the participants.

BENEFITS: There will not be any direct benefits to the participants.

CONTACT: If you have any questions about this study, please feel free to contact Dr. Janet Chang at 909-537-5184 (email: jchang@csusb.edu).

RESULTS: Results of the study can be obtained from the Pfau Library ScholarWorks (http://scholarworks.lib.csusb.edu) at California State University, San Bernardino after December 2018.

This is to certify that I read the above and I am 18 years or older.

_____ _____ Place an X mark here
Date

I agree to be audio recorded: _____ Yes _____ No

Demographics

Please answer the following questions:

1. Gender: M F
2. Age: 18-24 25-32 33-39 40+
3. Marital Status: Single Married Divorced Separated Widowed Other
4. Ethnicity: _____
5. Level of Education: AA or BA Degree, MSW Student, MSW Graduate, MA, MFT, L.C.S.W., D.S.W Other (Please specify) _____
6. Years of Service in the field of Social Work: 0-5 6-10 11-15 16+

Data Collection Instrument

Interview Questions

1. What client populations do you have experience working with?
2. What professional experience do you have providing treatment in chemical dependency?
3. What type of treatment is needed in a residential program to provide quality treatment for chemical dependency patients?
4. After graduating from a residential program, what factors do you think would cause a patient to relapse?
5. What factors do you think would help aid a client in maintaining sobriety?
6. How does being single or dual diagnosis differ during treatment?
7. What are your thoughts of the success rates of single versus dual diagnosis patient?
8. How do the social workers' perspectives on their patients success effect the quality of treatment given?
9. What can be done to raise the chance of long term sobriety maintenance?

Questionnaire developed by Samantha Ashley Navarro (2018)

DEBRIEFING STATEMENT

This study you have just completed was designed to investigate the perspectives on a clients' ability to maintain sobriety from social workers within the San Bernardino County. We are interested in assessing the perspectives of social workers on sobriety maintenance and how this may effect the treatment given. We are also interested in whether single diagnosis and dual diagnosis have different perspective of success rate. This is to inform you that no deception is involved in this study.

Thank you for your participation. If you have any questions about the study, please feel free to contact Dr. Janet Chang at 909-537-5184. If you would like to obtain a copy of the group results of this study, please contact the ScholarWorks database (http://scholarworks.lib.csusb.edu/) after September 2019.

APPENDIX B

INSTITUTIONAL REVIEW BOARD APPROVAL

CALIFORNIA STATE UNIVERSITY, SAN BERNARDINO
SCHOOL OF SOCIAL WORK
Institutional Review Board Sub-Committee

Researcher(s): Samantha Navarro

Proposal Title: social workers' perspectives on the ability to maintain sobriety after being successfully discharged from a residential treatment program

_SW1858_____

Your proposal has been reviewed by the School of Social Work Sub-Committee of the Institutional Review Board. The decisions and advice of those faculty are given below.

Proposal is:

__X__ approved

_____ to be resubmitted with revisions listed below

_____ to be forwarded to the campus IRB for review

Revisions that must be made before proposal can be approved:

_____ Student signature missing

_____ missing informed consent _____ debriefing statement

_____ revisions needed in informed consent _____ debriefing

_____ data collection instruments revision

_____ agency approval letter missing

_____ CITI missing

_____ revisions in design needed (specified below)

Committee Chair Signature — Date: 5/15/2018

Distribution: White-Coordinator; Yellow-Supervisor; Pink-Student

REFERENCES

Alcoholics anonymous (AA) (2011). Retrieved from https://www.alcohol.org/alcoholics-anonymous/

Baird, A.F., Campanaro, C.S., Eisele, J.L., Hall, T., & Wright, J.D. (2014). "How can we stay sober?" Homeless women's experience in a substance abuse treatment center. *Social Science and Public Policy, 51,* 404-407.

Bakker, A. B., & Costa, P. L. (2014). Chronic job burnout and daily functioning: A theoretical analysis. *Elsevier, 1, 112-119.*

Baldwin, J. A., Johnson, R. M., Gotz, N. K., Wayment, H. A., & Elwell, K. (2006). Perspectives of college students and their primary health care providers on substance abuse screening and intervention. *Journal of American College Health, 55*(2), 115-119.

Blume, A. W. (2016). Advances in substance abuse prevention and treatment interventions among racial, ethnic, and sexual minority populations. *Alcohol Research: Current Reviews, 38*(1), 47-54.

Brown, A.E., Pavlik, V.N., Shegog, R., Whitney, S.N., Friedman, L.C., Romero, C.,. . . Volk, R.J. (2007). Association of spirituality and sobriety during a behavioral spirituality intervention for twelve step recovery. *The American Journal of Drug and Alcohol Abuse, 33,* 611-617.

Flanagan, M. W., & Briggs, H. E. (2016). Substance abuse recovery among homeless adults in Atlanta, Georgia, and a multilevel drug abuse resiliency tool. *Best Practices in Mental Health 12*(1), 89-106.

Gil, A. G., Wagner, E. F., & Tubman, J. G. (2004). Culturally sensitive substance abuse intervention for Hispanic and African American adolescents: Empirical examples from the alcohol treatment targeting adolescents in need (ATTAIN) project. *Society for the Study of Addiction, 99(*2), 140-150.

Goldback, J. T., Thompson, S. J., & Holleran Steiker, L. K. (2011). Special considerations for substance abuse intervention with Latino youth. *The Prevention Researcher, 18*(2), 8-11.

Kaskutas, L. (2009) Alcoholics anonymous effectiveness: Faith meets science. *Journal of Addictive Diseases,* 28(2), 145-157.

Koehn, C., O'Neill, L., & Sherry, J. (2012). Hope-focused interventions in substance abuse counselling. *International Journal of Mental Health and Addiction, 10*(3), 441-452.

Laudet, A. B., Harris, K., Kimball, T., Winters, K. C., & Moberg, D. P. (2016). In college and recovery: Reasons for joining a collegiate recovery program. *Journal of American College Health, 64*(3), 238-246.

Litt, M. D., Kadden, R. M., Kabela-Cormier, E., & Petry, N. M. (2009). Changing network support for drinking: Network support project 2 year follow up. *American Psychological Association, 77*(2), 229-242.

Morris, T. (2006). *Social work research methods: Four alternative paradigms.* Thousand Oaks: Sage.

Oser, C. B., Biebel, E. P., Pullen, E., & Harp, K. L. H. (2013). Causes, consequences, and prevention of burnout among substance abuse

treatment counselors: A rural versus urban comparison. *Journal of Psychoactive Drugs, 45*(1), 17-27.

Polcin, D. L., & Korcha, R. (2017). Social support influences on substance abuse outcomes among sober living house residents with low and moderate psychiatric severity. *Journal of Alcohol and Drug Education, 61*(1), 51-70.

Rupert, P. A., Miller, A. O., & Dorociak, K. E. (2015). Preventing burnout: What does the research tell us? *Professional Psychology: Research and Practice, 46*(3), 168-174.

Substance Abuse and Mental Health Services Association (2011). *SBIRT: Brief intervention.* Retrieved from https://integration.samhsa.gov/clinical-practice/sbirt/brief-interventions

Servais, L. M., & Saunders, S. M. (2007). Clinical psychologists' perceptions of persons with mental illness. *American Psychological Association, 38*(2), 214-219.

Siporin, S., & Baron, L. (2012). Incorporating nondrug social & recreational activities in outpatient chemical dependency treatment. *International Journal of Mental Health and Addiction, 10*(1), 97-106.

Skeer, M. R., Yantsides, K. E., Eliasziw, M., Carlton-Smith, A. R., Tracey, M. R., & Spirito, A. (2016). Testing a brief substance misuse preventative intervention for parents of pre-adolescents: Feasibility, acceptability, preliminary efficacy. *Journal of Child and Family Studies, 25*(12), 3739-3748.

Stead, P., & Viders, J. (1979). A ‘sharp’ approach to treating alcoholism. *Social Work, 24*(2), 144-149.

Stuyt, E. B. (2014). Enforced abstinence from tobacco during in-patient dual-diagnosis treatment improves substance abuse treatment outcomes in smokers. *The American Journal on Addiction, 24*(3), 252-257.

United States Census Bureau. (2017). *Quickfacts: San Bernardino County* [Data file]. Retrieved from https://sanbernardinocountycalifornia,CA/PST045217, PST045216

United States Department of Labor. (2017). *Bureau of labor statistics: Labor force statistics from the current population survey* [Data file]. Retrieved from https://www.bls.gov/cps/cpsaat11.htm

Van Dernoot Lipsky, L. [Ted Talks]. (2015, April 23). *Beyond the cliff.* [Video File] Retrieved from http://www.youtube.com/watch?v=vOzDGrcvmus