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CO-CREATING SOLUTIONS FOR SUBSTANCE ABUSE

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The national standard for addiction counselors is to view substance abuse as a disease (National Association of Alcoholism and Drug Abuse Counselors, 1996). Addiction is viewed as a lifelong affliction that is progressive and requires years of therapeutic intervention coupled with active participation in a 12-step oriented support group. It is a model in which the therapist is the expert. The purpose of this article is not to challenge the effectiveness of this model. Instead, it is to explore an alternative approach in which solutions are co-created by the client and the counselor. This article presents an innovative and empowering counseling approach for substance abuse treatment. An emphasis on the application of this model to the child welfare population is included to demonstrate its impact.

The devastating effects of alcohol and drug abuse are not a new phenomenon in the United States. Addictions like alcoholism cause employment absenteeism, repeated accidents, neglect of family responsibilities, deterioration of health, repeated drunk driving arrests, and financial difficulties (Liska, 1990, p. 241). Studies show that laboratory animals prefer cocaine to food, water, and sex. They will self administer this drug until they overdose and die (Liska, 1990, p. 176). Human behavior is similar. Reform activities have often been employed in an effort to minimize the damage to society.

The American Society for the Promotion of Temperance was founded in 1826, and it played a significant role in the prohibition movement (Axinn & Levin, 1992, p. 43). In 1896, Jane Addams and the Hull House staff successfully lobbied the saloon keepers to prohibit the sale of alcohol to minors (Addams, 1910). Mothers Against Drunk Driving (MADD) was successful in lobbying for

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a 21-year minimum drinking age (Liska, 1990, p. 238). Society continues to utilize legislation to minimize the effects of alcohol abuse. In 1999, New York City began seizing cars driven by intoxicated owners (Thompson, 1999) in an effort to curtail drunk driving.

However, legal action has not been the only approach utilized to solve this problem. Even during the prohibition movement, treatment was provided to those who suffered from alcoholism (Richmond, 1917). In the 1990s, treatment programs were plentiful across the country. The numbers of those seeking treatment have grown; in 1996, there were 1,534,045 clients admitted into substance abuse treatment programs nationwide as compared with 1,479,993 clients who were admitted in 1992 (Department of Health and Human Services [DHHS], 1998, p. 36). What difference are these treatment programs making toward resolving this ongoing problem? How do we know if a treatment program is effective? Are these treatment programs actively searching for new and more effective interventions, or are they using the same approach used during the prohibition movement with the expectation of different results?

The staff of the Jefferson County Department of Health and Environment, Substance Abuse Counseling Program (SACP), has studied the research on what causes change in behavior, and we have discovered a way to assist clients in the overwhelming process of changing their drug/alcohol-using behavior. We have implemented Solution-Focused Therapy (de Shazer, 1985) in a way that we have found to be effective, and we have sought to document this effectiveness through the use of client data and surveys. We have learned a significant amount from our clients and our mentors. We hope to continue learning, and we would like to pass our knowledge on to you, the reader. A brief step back through time may help to understand where we are today and how we got there.

HISTORICAL BACKGROUND OF ADDICTION TREATMENT

In the early twentieth century, professionals were beginning to understand addiction as a disease rather than a moral problem. Treatment given during the prohibition movement was often based on this disease concept (Richmond, 1917). The formation of Alcoholics Anonymous in 1935 was valuable in providing much needed guidance for struggling physicians as they grappled with the medical and psychological needs of their patients. A doctor writes, "We doctors have realized for a long time that some form of moral psychology was of urgent importance to alcoholics, but its application presented difficulties beyond our conception" (Alcoholics Anonymous, 1976, pp. xxv). During the 1960s, alcoholics were viewed as "people who were ill" (Sournia, 1990, p. 123). During the 1980s, residential treatment programs were the treatment modality of choice, and the rhetoric of experts such as John Bradshaw (1988), Claudia Black (1985), Pia Mellody (1989), and Sharon Wegscheider-Cruse (1981, 1985) was common

in workshops, colleges, and universities for addiction counselors. If a counselor was "recovering," he/she was considered to be more marketable, and this personal experience was often considered to be more valuable than formal education.

The disease model (Fingarette, 1988; Peele, 1989) had become the predominant paradigm. According to Peele (cited in Miller & Berg, 1995), a Gallup poll found that "nearly 90 percent of Americans believe that science has proved that alcoholism is a disease" (p. 13). However, not all professionals agreed that the field of substance abuse was heading down the best path, and the field of addictions was beginning to be challenged. Davies (1962) tainted the disease concept with his look at spontaneous remission of problematic drinking in supposed alcoholics. Miller and Berg (1995) state that the claim that alcoholism is a disease is scientifically unfounded (p. 13). Bateson's (1972) statement that "Alcoholics Anonymous . . . has the only outstanding record of success in dealing with alcoholics" (p. 310) was being disproved. As we entered the 1990s and managed care began to be the norm, agencies were asked to demonstrate that the methodologies used were both clinically and cost effective. The question, "Where is your evidence?" was not welcome to many. Yet the question signaled a need for examination. In order to survive, agencies had to look to new ideas and be accountable.

CURRENT TRENDS IN ADDICTION TREATMENT

Although many of today's counselors have mastered the application of motivational techniques (Miller & Rollnick, 1991), the basic tenets of the disease model (Fingarette, 1988; Peele, 1989) permeate the current treatment modalities. Addiction continues to be viewed by many as a lifelong problem. Attendance of 12-step recovery meetings is often mandated as part of treatment regardless of individual client benefit. Yet, in many ways, this creates a double bind for clients. "If your goal is not to do something—like drinking—then you can never be finished with the treatment because the problem may recur at any time" (Miller & Berg, 1995, p. 53). While this approach is useful for some, this lifelong view of addictions does not take into account the many clients we have seen in our treatment program who have been successful without dependence on a counselor or on a life dominated by meetings. According to cognitive theory, the more a client tries to not think about something the more impossible that task becomes (the pink elephant syndrome). Many times "attendance at recovery-oriented meetings often triggers the very thing it is supposed to help stop" (Miller & Berg, 1995, p. 52). Clients are often encouraged to focus on their past substance use and on the consequences of this use. Human behavior follows thought (Greene & Ephross, 1991). What are we, as treatment agencies, asking that our clients think about on a consistent basis? Do we want clients to gravitate

toward health or dysfunction? Positive change is the key to successful therapy. All human beings are in a state of change. Change is inevitable (de Shazer, 1985, p. 137; Berg, 1994, p. 4). Clients can choose to make either positive or negative changes, and these changes are influenced by their thoughts. Which type of changes would we prefer our clients make?

The majority of treatment agencies continue to have predetermined treatment programs with set educational, therapeutic, and relapse components. Although many profess that their services are individualized according to client need, the content of the program has already been determined before the client seeks admission. Clients are often assigned to groups based on their gender and according to issues that the counselor has identified. Clients are labeled as "in denial" unless they confess that they are alcoholics or drug addicts, or they are labeled as resistive if they do not believe they have a problem. The clients' dysfunction remains the focus. Many counselors claim to have changed their therapeutic approach to be solution focused. However, what these counselors often mean is that they now look for clients' strengths to help them solve the problems they diagnosed in their clients. Although using the clients' strengths is a marked improvement, it is not enough.

A NEW WAY OF PROVIDING ADDICTION TREATMENT

Philosophy

Our philosophy can be summarized in a few words. The client is the expert on what will work and what he/she wants for the future. In this regard, we agree with Carl Rogers' Client Centered Theory (Rogers, 1951; Rogers, 1957). Carl Rogers (1957) wrote that empathy, warmth, unconditional regard, genuineness, and congruence were necessary for change to take place. Listening to the client and believing in the inherent good in the client are the basic elements of respect. We share the experience that Duncan, Hubble, and Miller (1997) described when they reported that many of their clients report that common courtesy was new to them. The clients told us that they had felt "disbelieved or disliked by previous clinicians, rarely appreciated for their insights or capabilities and even less frequently courted for favorable impressions of the process" (p. 29). Insoo Berg (1994) states that "when clients believe you are interested in them and want to work with them, they are more likely to cooperate and work with you and to make changes" (p. 52). A probation-referred client recently told us, "I really liked that you treated us like individuals rather than criminals." Much focus is given to technique and to the counselor's action in treatment; however, "the client is actually the single, most potent contributor to outcome in psychotherapy" (Miller, Duncan, & Hubble, 1997, p. 25). For any treatment to be effective, the client must have a positive perception of the counselor and what the counselor is doing (Miller et al., 1997, p. 25). The counselor assumes a non-

expert position. "The non-expert position does not mean that one lacks experience, or knowledge, or theory" (Bobele, Gardner, & Biever, 1995, p. 16). It means that we do not assume that we know what is best for the client based on a preconceived body of knowledge. Understanding and respecting the client's view of the world, the problem, and the solution are key to change. We find it most effective to work with the client's perceptions rather than to try to change these basic elements. We know that "for change to happen, the client needs to make a perceptual and cognitive shift and to do something that is behaviorally different from what he [or she] has been doing" (Berg, 1994, p. 51). We find that the counselor is most effective in assisting in this process when the counselor is in partnership with the client.

The substance abuse field has not done well in determining the etiology of addiction. Fingarette (1988) states that "the attempt to find a single catchall 'cause' of a single 'disease' has repeatedly led researchers astray" (p. 65). Miller et al. (1997) speak to the subjectivity of etiology by stating that "it seems that the etiology of a particular client's problem depends, for the most part, on the particular therapist that the client happens to see" (p. 126). How important is etiology? Do counselors really need to know why in order to help the client? How strong is the relationship between cause and solution? Many writers state that there is often no connection, and, in fact, the time spent looking for the cause may not only be a waste of time, but may also have harmful results (Miller & Berg, 1995; Miller et al., 1997).

We have found that what is important in our work is the client's belief about etiology. We do not try to change a client's understanding about the cause of his/her problem. It is irrelevant to the solution. Studies show that a client's belief about the cause of the problem is not related to outcome. What is important is that the client's belief about the cause is respected (Duncan et al., 1997, p. 30). Our counselors take a neutral stance regarding etiology. It is this neutral stance that allows the clients to explore what works for them.

The traditional counselor role as expert has proven problematic. Counselors are trained to look for problems. We are good at it. We find comfort in being able to label something and to know the prescribed course of action required for any set diagnosis. Miller and Berg (1995) state, "The typical alcohol counselor . . . is bombarded with information that is, by and large, limited to the 'three Ds': disease, denial, and dysfunction" (p. 12). Miller and Berg (1995) conducted some experiments in which they showed a group of therapists a videotape of a family they had interviewed. They asked these therapists to give their observations. The therapists quickly offered their evaluation of the family's dysfunction and their prescribed treatment. They later learned that this family was not dysfunctional at all and was in fact a functional family (pp. 10–12). Miller and Berg go on to say that they "were shocked by the sheer magnitude of 'sickness' that the therapists found in the well-functioning family" (p. 12). Many of the models that addiction counselors revere, such as the dysfunctional family roles

(Bradshaw, 1988; Wegscheider-Cruse, 1981, 1985), reinforce and "prejudice the therapist to see only what's wrong in the family" (Berg & Reuss, 1998, p. 106). Berg and Reuss further state that these models do "not coincide with our clinical experience" (p. 106). Since the clients are the experts in our model, the role of the counselor must shift to that of a consultant.

The Role of Referral Sources

The majority of the clients who come to SACP are referred by community agencies. These agencies often identify substance abuse as a problem for the client prior to the client coming to this conclusion. Consequently, many of our clients are externally motivated for treatment. Approximately 40% of our clients are involved in the Social Services' system. Protecting children is paramount. An analysis of the data reported by the four Colorado counties that have already implemented the Child Welfare Expedited Permanency Planning program revealed that 43% of these cases were impacted by parental substance abuse (Schene, 1998). However, it is thought that this number may be low. Berg (1994) states that an estimated 50 to 80% of child welfare family-based services cases involve substance abuse (p. 207). Over a seven-month period, 56% of the cases staffed by the Service Utilization Review Team at a local department of Social Services were substance related (substance use by the child, parental unit, or both). Unless parents learn to deal with life issues in a way that does not involve substance abuse, children will not be safe. SACP has formed a partnership with this local department of Social Services to increase identification of clients in need of substance abuse treatment services and to ensure that these services are available to this population. These clients are often angry that Social Services is involved in their lives. This involvement is seen at times as meddling or intrusive. The clients may not see treatment as necessary or useful in reaching their goals.

One might ask how a client who does not want to be in treatment can be effectively given the power to be the "expert." We find that many of our clients are surprised that we are not going to label them as "alcoholics" or "drug addicts." They tell us that they are relieved to learn that we will listen to them and hear what they want. Inevitably, the client and the referral source want the same thing (i.e., to have their children in a safe environment, to be good parents, and to stay out of the legal system). By focusing on what the client and the referral source both want (and assisting them in negotiating a common goal if needed), the counselor is able to remain neutral. It is only by staying neutral that we are able to avoid taking sides and we are able to be effective (Berg & Reuss, 1998, p. 134). We assist the client in determining what he/she will need to do to reach his/her goal (e.g., create a drug-free environment, obtain stable employment). We often find that when the client is able to complete these goals, the substance abuse issue disappears. It may seem surprising, yet clients want assurance that the counselor knows enough about them to ensure that the coun-

selor can help them to reach their goals. This means that clients often volunteer information that would otherwise be kept hidden if we employed a more problem-oriented approach.

Our referral sources are extremely important to us, not only because they are the source of our clientele, but also because they often have a long history with our clients. We depend on them to be a part of treatment and to provide information to us about what they expect their clients to gain from treatment. They are also in a position to let us know what progress they are observing in the client. The caseworkers have invaluable information about the children and the home life that we need in order to know that the children's safety is ensured. If substance abuse is continuing in the home, we want to know. We use that information to assist us in remaining objective. If conflicting information is provided, we remain neutral as we express our confusion to the client as to how both sides of the story can be true (de Shazer, 1985; Miller & Rollnick, 1991; Berg & Reuss, 1998). This is only effective if the counselor is genuine. If the counselor believes that the client has negative intent, the client will know this and it will be harmful. We believe that clients truly want to reach their goals. They may not always know the most effective approach. This philosophy ensures that we are able to see the positive aspects of our clients and that we will be able to assist them in their journeys.

Individualization of Treatment and the Impact on Women

We believe that clients are unique, and, therefore, we strive to make all elements of treatment individualized. Berg (1994) states that "the available research suggests that an individualized treatment approach works best " (p. 208). Even if the problem is the same, one person's solution will be very different from the next. People see things and understand things differently. What works for one will not necessary work for another. "The trick of successful treatment is to design an approach that fits the unique needs of the individual client" (Miller & Berg, 1995, p. 16). Clients are asked to identify the goals they want to set, decide if they prefer gender specific vs. mixed gender groups, and many other elements of their services. Miller and Rollnick (1991) refer to this as a "menu of alternative strategies" (p. 33). However, the clients are then held accountable. If, for example, a female client chooses to be in a mixed gender group and then appears to be hesitant to address some issues in the presence of the male clients, we would ask the client if her decision to be in a mixed gender group is going to be effective in assisting her in working toward her goal. Many times we find that this intervention alone is effective in assisting the client to determine what she needs and how important her goal is to her. The client then takes responsibility for her decision and what is best for her. Regardless of the client's decision, the client is invested in the solution because it was done in partnership

with her. The referral source's needs are met in that the client's apparent lack of progress was addressed promptly.

Creating specialized services for women is becoming more common in the field of substance abuse. This is necessary because the field of addictions has been slow to discover that "women's use and misuse of substances are very different than men's, as are their concerns and way of constructing solutions" (Berg & Reuss, 1998, p. 151). Berg and Reuss go on to say that the "treatment must be sensitive to the special needs of women" (p. 151). In many treatment programs, women are strongly encouraged to attend women's groups to obtain gender-specific treatment. In some cases, the women are assigned to gender-specific groups as a part of the prescribed course of action. Though we definitely do not disagree with the effectiveness of women's groups, we agree with Berg and Reuss (1998) when they state that the "best way to be sensitive is to *ask* women what they need to help their recovery along, then listen to them without preconceived ideas of what they need" (p. 153). We were surprised to learn through a recent SACP survey that 97% of our clients (both men and women) were not interested in gender-specific groups. Even more surprising was that the 3% of clients who were interested were male. It appears that when we individualize every aspect of client care, there is a marked decrease in the client's desire and need for specialized services to be offered to a subgroup. In fact, we have learned that the concept of gender groups was viewed by some clients as a form of discrimination. Many clients expressed concern about losing the insight and feedback that the opposite gender provides. Our critics state that our female clients may be declining to participate in gender-specific groups in an attempt to avoid painful issues. While we respect their philosophical stance, we have not found this to be the case. This same SACP survey indicated that our clients feel comfortable discussing whatever issues they need to in their current group setting. Each client was asked to rate his/her comfort level on a 10-point scale (1 = not at all comfortable, 10 = very comfortable). The average client score was 7.7. It is important to note that 92% of those surveyed were referred by external sources and did not seek treatment voluntarily (61% were referred by Social Services). The two clients who rated themselves below a "5" on this scale had just started the group process, and both stated that "nothing you [the agency] could do will help" at this time. We asked all of our clients what we could do to increase their comfort level in the group setting. All of the clients' responses were unrelated to gender issues and were similar to this client's response, "Nothing, it is my own insecurities that I need to overcome."

Theories

Solution-Focused Therapy (de Shazer, 1985) is key to our treatment approach. It is the foundation. We have studied the works of de Shazer (1985, 1988, 1991, 1994), Berg (1994, 1995), and the combined work of Berg and Miller (1992),

Berg and Reuss (1998), and Miller and Berg (1995) to learn how to apply these concepts effectively to the field of substance abuse. The simplistic definition of the solution-focused approach is that it focuses on solutions rather than problems (Miller & Berg, 1995, p. 15). This may seem optimistic to think such an approach could be effective, yet this concept has been successfully used by alcoholics since the development of Alcoholics Anonymous. The Big Book of A.A. (Alcoholics Anonymous, 1976) states, "When I focus on what's good today, I have a good day, and when I focus on what's bad, I have a bad day. If I focus on a problem, the problem increases; if I focus on the answer, the answer increases" (p. 451). It further states, "When I stopped living in the problem and began living in the answer, the problem went away. From that moment on, I have not had a single compulsion to drink" (p. 449). Our clients tell us similar stories. Many of our clients come to us believing that their substance use is not a problem. We ask them to focus on how they want their life to be. Within a short period of time, many report changes that their children and loved ones are noticing in them. Several fathers have told us excitedly, "My kids are happy to see me when I come home now!"

"Solution-focused therapy assumes that even a complicated problem begins to be resolved with a simple solution (one that is often overlooked by the client and by a therapist who is looking in the wrong direction)" (Berg & Reuss, 1998, p. 153).

Our critics state that this approach will work with the uncomplicated cases, though not with the more complex ones. That has not been our experience. We often find that the clients who have failed at other more traditional treatment do well with this approach. Those clients have often lost hope and have been portrayed as difficult cases. Once they experience success, their thirst for change is uncovered. "Pessimistic attitudes conveyed to the client by an emphasis on psychopathology or the difficult, long-term nature of change are likely to minimize or curtail the effect of these factors [expectancy and hope]" (Miller et al., 1997, p. 31). People who are optimistic and believe that change is possible demonstrate better psychological health (Taylor, Wayment, & Collins, 1993). Alcohol and drug addicted clients, in general, are often classified as difficult cases. Miller and Berg (1995) state that it is their experience that alcohol dependent "clients want to and do recover from alcohol problems rather rapidly" (pp. 22–23). Steve de Shazer (1994) states that they treated alcohol- and drug-related cases " 'as usual' and the success rate for the 'abuse' cases turned out to be no different from that for other cases" (p. 242). Steve de Shazer (1991) cites an "80.4% success rate (65.6% of the clients met their goal while 14.7% made significant improvement) with an average of 4.6 sessions. When recontacted at 18 months, the success rate had increased to 86%" (p. 161). Miller and Rollnick (1991) state that "relatively brief counseling can have a substantial impact" (p. 32).

Outcome studies have also been done with impressive results using the solution-focused approach with mental health clients (Beyebach, Morejon, Palen-

zuela, & Rodriguez-Arias, 1996), clients with chronic schizophrenia (Eakes, Walsh, Markowski, Cain, & Swanson, 1997), and clients in the prison system (Lindforss & Magnusson, 1997). Insoo Berg stated that "Steve de Shazer and Dr. Luc Isebaert have experienced good success in their work with substance abuse clients in Belgium." She reports that "in a 5 year follow-up study, 86% of clients and their families report that over-all life is better for them. When asked how they felt most of the time, 88% reported doing well, feeling good, or feeling very good. In addition, 69% reported that their family relationships had improved since the hospitalization. Seventy-nine percent reported that they had received no further treatment for alcohol-related problems since discharge" (personal communication, 1999). This model (the Brugge Model) emphasizes client choice. Clients are encouraged to design their individual treatment program and may change their treatment as they see necessary at any point.

In addition to Solution-Focused Therapy, SACP incorporates the work of Prochaska and DiClemente (1984); Prochaska, Norcross, and DiClemente (1994); and Miller and Rollnick (1991). Motivational interviewing (Miller & Rollnick, 1991) is "particularly useful with people who are reluctant to change and ambivalent about changing" (p. 52). We believe that counselors must understand the process of change and work with the client in a respectful manner regardless of the client's belief about the existence of a problem. Alcoholics Anonymous (1976) states that a client should not be "pushed or prodded . . . the desire must come from within" (p. 95). By focusing on what a client wants, internal motivation builds. Clients are more likely to work for something that is important to them. We find that clients are more likely to honestly explore what they want for their future, if they do not fear judgement from the counselor. We find that the "simplest and least invasive approach is frequently the best medicine" (Miller and Berg, 1995, p. 20).

Lastly, we have studied the work of Budman and Gurman (1988). These authors stress the importance of being flexible in the frequency and duration of treatment. They encourage counselors to "place particular emphasis upon making maximal use of early sessions in a given episode of care, and . . . consider a move to less frequent or less 'time-intensive' visits later in a given episode" (p. 285). They state that episodic care is more effective in that it allows clients to "clarify and consolidate gains" (Budman & Gurman, 1988, p. 290). When clients are encouraged to test their skills in the real world and are given the freedom to return to treatment without fear of the stigma of failure, they are more likely to ask for help earlier in a potential crisis. This is especially useful in the work with Social Services' clients, for whom child safety is of utmost importance. Budman and Gurman (1988) state that their "experience has been that patient's returning often indicates not only that a positive working alliance has been established, but also that the patient has derived some benefit from his or her initial therapy experience" (p. 287).

APPLICATION

Evaluation and Treatment Planning

SACP counselors use extensive evaluative instruments during the initial evaluation sessions with the clients. These instruments are invaluable in our expected role as the "expert" as required by our referral sources, while allowing us to remain neutral and therapeutic with the clients. The role of evaluation is to gather evidence. The client is in charge of what evidence exists. Our role is to report that evidence to the courts and to the referral sources. If there is not enough evidence for us to say that the client does not have a problem with substances, we show that to the client and ask what he/she would like to do. This empowers clients to work to create positive evidence both during the initial evaluation and throughout treatment. We also use the evaluation tools to see the world from the client's perspective. We do our best to gather competency-based information (Berg & Reuss, 1998, p. 101). When inconsistencies exist, we use the intervention of "confusion" (de Shazer, 1985; Miller & Rollnick, 1991; Berg & Reuss, 1998) to understand how both can be true. This also helps the clients to explore possible inconsistencies within themselves. We review the results of all evaluative instruments with the client in a "*motivational* fashion" (Miller & Rollnick, 1991, p. 90). Information is always presented in ways that focus on the client's strengths, and which complement information that the client has directly stated. If the client disagrees with the information gathered, we are eager to understand the truth from the client. We know that instruments can be wrong. We work together to discover what we can do to help them obtain the evidence they need. As one SACP counselor stated, "It's like looking into a crystal ball! Clients are amazed how well we know them and how accurate the information is." We use the information as an open forum to discuss and explore how the clients would like their lives to be, in what ways their lives are working for them, and how they would like for it to be different. "This process of solution development can be summed up as helping an unrecognized difference become a difference that makes a difference" (de Shazer, 1988, p. 10).

The treatment planning process (or goal development) begins during this evaluation. A small goal is identified by the client as a starting point. The counselor is there to help the client to clarify that what the client has identified is most important to him/her. The counselor also points out inconsistencies and helps to ensure that the goal is small and focused. We know that the success rate (particularly with substance abuse clients) increases when the client participates in this process (Berg, 1994, p. 211). Steve de Shazer (1985) states that "only a small change is necessary, and therefore only a small and reasonable goal is necessary" (p. 16). We know that "a small change in one person's behavior can make profound and far-reaching differences in the behavior of all persons involved" (de Shazer, 1985, p. 16). Sometimes the clients' goals are simply to provide evidence to their referral sources that they do not have a problem with sub-

stances. By working on this goal, the clients will either prove this to be true or will discover another goal that is important for them to obtain. Often other goals are identified during the treatment process. These are then clarified and formulated into treatment plans.

Referral sources who are not familiar with this approach can become initially frustrated at the apparent lack of connection between the problem and the solution. For example, Jennifer was referred to our agency by Social Services due to her alcohol use. She was also involved with the legal system due to her five felonies and her charge of sexual assault on a child. Her probation officer described her as "manipulative and angry." She further stated that the client "needs to see that she is a child molester." The client repeatedly denied these accusations and would become escalated when these statements were made in her presence. She stated that she was afraid to go to prison and would do "anything to get my kids back." Our approach with the client did not include insisting that she "confess" or label herself as an alcoholic or child molester. We simply asked her the following question: "Suppose that a miracle happened while you were asleep tonight. And the miracle is that you are at peace with yourself whether or not you end up in prison . . . somehow you have found peace . . . to make it through . . . But since you were asleep, you don't know that the miracle has happened. What will you notice when you wake up that lets you know this miracle has happened and that you have found peace?" The treatment plan that the client created after she answered this question was to explore how she wanted her life to be despite the impending legal consequences. She later reported that most of her miracle has come true. She reported that she has moved into her own residence and has her "own things back." She further stated that her probation officer stopped by and that she felt "proud to show her my new home." She described this as a "symbol" of all she has accomplished. The client's mother recently reported that she now trusts the client again and believes that the client "deserves and can handle having her boys back." The client's caseworker is now working toward reunification of the children.

Application to Group Therapy

Traditionally, drug and alcohol treatment groups have an educational or a philosophical agenda. Many times that agenda is to "pressure newcomers into accepting this treatment plan [disease concept of addiction] by seasoned members" (Berg & Reuss, 1998, p. 137). We have not found this approach to be effective, and we do not use formal education groups. Consistent with our approach, we have not found any consistent topics on which all clients lack education. Therefore, our groups are treatment-plan driven. If education in a particular area is needed, this is written into the client's treatment plan.

The group begins with each client reviewing what he/she has worked on to reach his/her goal since the last contact with the agency. Every change and

every effort, regardless of size, is important. From this treatment plan discussion, topics naturally emerge that the clients identify as useful to discuss to help each client reach his/her individual goal. Frequently, the group leader uses the Miracle Question (de Shazer, 1988, 1994; Berg & Miller, 1992; Berg, 1994; Berg & Reuss, 1998). This intervention is an effective "way to begin constructing a bridge between therapist and client built around the (future) success of the therapy" (de Shazer, 1994, p. 95). Other classic solution-focused interventions are often used in the group setting to assist the clients with obtaining their goals. Clients are encouraged to notice times that the problem does not exist (de Shazer, 1991). Paying attention to "those times when a person either does not drink or does not have a drinking problem . . . is often extremely helpful in providing clues to the solution of his [or her] alcohol problem" (Miller & Berg, 1995, p. 79). Noticing difference (de Shazer, 1988) is also an effective way to encourage change. This intervention creates excitement and hope for the future. "Solutions develop when the therapist and client are able to construct the expectation of a useful and satisfactory change" (de Shazer, 1985, p. 45). When the group ends, each member returns to his/her treatment plan and decides what next step is necessary to complete to work toward charge. Each client writes down what he/she is planning to do, and these group notes become part of the client's agency record. We find this process helps to hold both the client and the group leader accountable. The group leader points out inconsistencies if the client's plan does not appear to be connected to the stated goal. Many times the client explains the connection, other times the treatment plan is modified to be more accurate as to what the client truly wants.

In addition to group treatment, clients are encouraged to include family members and their dependent children in the treatment process. As with all treatment decision, clients are empowered to decide who should participate, how they should participate, and when. A children's group is available for the clients' dependent children. This group is run by utilizing solution-focused interventions and is designed to assist the children in coping with parents who are changing substance abusing behaviors. Clients are encouraged to bring family members to the specified family sessions when they see this as beneficial. Family members are asked what differences they see in the client and what differences these changes are making. We find that this is useful in reinforcing client change and in identifying change that would otherwise go unnoticed.

Relapse is common in substance abuse, and "most experts in the field of alcohol treatment contend that one or two relapses a year is considered normal" (Berg, 1994, p. 212). Because of this, relapse prevention is a standard component of any substance abuse treatment program. SACP is no exception. However, we take an unique approach. Charlie Johnson, LCSW, created a technique called the Emergency Roadside Repair Kit (personal communication, 1997), which we find invaluable with our clients. It is especially useful with clients who believe that relapse will never happen to them. We ask clients to think of

what types of emergency equipment they carry in their cars and why they find it necessary to have it. Most clients readily state that they are not planning to have a flat tire, yet they would hate to be stuck somewhere unprepared. Suddenly, the idea of having tools on hand to solve potential life problems makes sense. This is particularly useful for Social Services' clients. This intervention helps them to be able to plan for ways to keep their children safe in the event that relapse does occur. We predict that clients will be more likely to ask for help in the future if they have a positive experience during their current treatment episode. This increases the likelihood that clients will ask for help sooner during the development of a future crisis.

Application to Discharge Planning

Clients are encouraged to engage in treatment for short periods of time (4 to 6 weeks). Once the client has completed that initial time commitment, the client, referral source, and the counselor determine if additional services are necessary. Sometimes that is all the services that are needed. Other times, additional services at the same frequency are determined to be helpful, or a decrease in frequency (e.g., bimonthly or monthly) is determined to be the best course of action. The decision is based upon the client's progress toward his/her goals. Sometimes the clients state that additional goals are needed to reach their long-term plans. We are amazed by the dramatic changes we see in our clients. "While the rate of change varies some for each therapist and client, you should begin seeing change within weeks rather than within months or years" (Miller & Berg, 1995, p. 152). It is relatively common to see a client in his/her first group, arms crossed in a defiant you-can't-make-me-do-anything pose. Yet, within a week or so, this same client is actively participating in the process and is excited about the changes he/she has made in his/her life. Miller & Berg (1995) further warn clients to "steer clear of treatment professionals who say that treatment and recovery are necessarily a lifelong process" (p. 152).

Discharge occurs when the clients reach their goals. "The object [of therapy] is to get the client out of therapy and actively and productively involved in living his or her life" (Dolan, 1985, p. 29). The client's goals are continuously reviewed (in each group and individual session) to ensure that the goal is still what the client has chosen and that the client is actively working toward the identified solution. Accountability of both client and counselor is key to our model. "In solution-focused therapy . . . the client's goal achievement signals to client and therapist alike that a solution is developing or has developed" (de Shazer, 1991, p. 121).

Application to Supervision

All counselors employed by SACP must strongly believe in the philosophy, theories, and interventions we use. "Research confirms that therapists enhance

the placebo component of the procedures they employ when they truly believe in and are confident that the procedures will be therapeutic" (Miller et al., 1997, p. 131). The counselors do not use any self-disclosure with the clients. Consistent with our theory, what worked for a counselor is irrelevant to what might work for a client (similar problems do not mean that the solutions will be similar). We have found that this forces us to be more professional and to depend on other interventions to convey the understanding and compassion that clients seek. We find that clients rarely ask us if we, ourselves, are "recovering." Many of us came from environments in which self-disclosure was accepted, if not encouraged. We find that not disclosing is much more effective in helping the counselor to stay present emotionally for the clients (the clients also confirm this). It also ensures that the counselors remain focused on the clients' solutions rather than on what worked for the counselor. Needless to say, hiring can be a difficult and frustrating process. However, it is due to this fact that our staff turnover is very low and employee morale is high. We have not lost a core team member since 1996 (when we first implemented this approach).

Our team consists of this author (the Program Coordinator), seven core team members, and up to three on-call members. We are a very close-knit team. We have found that new team members have been surprised at the degree of teamwork that we expect. Our definition of "team signifies an attitude toward clinical practice and learning that values, honors, and entails openness, sharing, collaboration, and flexibility" (Anderson & Swim, 1995, p. 3). Our philosophy applies to our team and to supervision as well as to client care. We have found that this approach is not something that one can do from nine to five and then return to a problem-focused personal life. We challenge and are challenged by our team members in an effort for professional (and ultimately personal) growth. Counselors are encouraged to co-design the program and to evaluate the program's application of current research and its effectiveness. "There is an emphasis on the crisscrossing of ideas" (Bobele, Gardner & Biever, 1995, p. 15) as we troubleshoot issues and learn from one another. As a team, we periodically look at the program as a whole and what we could do differently to improve (similar to what we ask from our clients). Team members are encouraged to work through personal issues that impact their work and to practice direct and honest communication with other team members. Professional growth is a core value. The core members are dedicated to our philosophy and to the success of the program.

Needless to say, this can be a challenging group to supervise. They are independent thinkers and can be strong willed at times. That is precisely what makes them excellent counselors and effective in implementing this approach. Supervision is viewed as the "entertainment of multiple and contradictory ideas at the same time. All ideas are potentially useful even if they contradict one another" (Bobele et al., 1995, p. 19). Although we "assume that clients are the primary experts on living their lives, we do not make the assumption that supervisees

are already experts on how to do therapy. We believe that our supervisees have some natural skills, abilities, and talents that can be focused and enhanced" (Bobele et al., 1995, p. 18). During supervision, client and group issues are discussed and effort is taken to ensure that counselors are using the interventions and philosophy in a consistent manner. Videotaping is also used for training purposes. All team members participate in the clinical process session each evening after the client groups. This allows the counselors to debrief, receive peer and supervisory consultation, and to learn from the groups' successes and struggles. This approach was very new to all of our therapists, yet all came to us with some common traits: curiosity, dedication, and respect for change. Supervision "invites the supervisee into a shared inquiry—a mutual puzzling, curiosity, and exchange concerning the 'problem' and its 'solution'" (Anderson & Swim, 1995, p. 5). When we lose our curiosity about what makes a difference for a client, we become ineffective and risk burn-out.

Outcome

One may ask, "Where is your evidence that this approach is effective (specifically for the Social Services population)?" Client feedback is critical to our approach. We use client focus groups to engage in informal dialogue with our previous clients. Focus groups are useful in identifying "major themes" (Krueger, 1994, p. x) and how we are perceived by our clients and their family members. Focus groups also communicate to our clients that we are interested in their opinions even after they are discharged. In addition, we have used four ways to evaluate our program. Since individualized treatment planning is the key to this model, we track the percentage of the treatment plans that our clients complete. Our first evaluative method is an analysis of this data. We have found that the majority of our clients complete 75% or more of their treatment plans (see Table 1). These results indicate that the majority of SACP clients are making behavioral changes that can be observed and noted by the therapists. The Social Services referred population appears to complete a slightly higher percentage of their treatment plans as compared with the general SACP population. This may be due to the high degree of external pressure placed upon them by

Table 1. Percentage of the Treatment Plans Completed by Clients

	All SACP Clients (%)	Social Services Clients (%)
Completed 100% of Tx Plan	57	69
Completed >74% of Tx Plan	66	80
Average Percent of Tx Plan Completed	76	86

Social Services and the legal systems. Many of the non-Social Services clients do not have this degree of external pressure. This slight increase may also be due to these clients' internal desire to regain custody of their children.

Decreasing the clients' overall negative symptoms is a common goal of therapy. Our second evaluative method is commonly used by managed care in an effort to document that negative symptoms are decreasing as a sign of effectiveness of treatment. We ask each adult client to complete the OQ-45.2 (American Professional Credentialing Services [APCS], 1999) at admission and discharge. We also ask each adolescent client's parent or guardian to complete the Y-OQ-2.01 (APCS, 1999) at admission and discharge. (It is important to note that clients who do not complete the exit session do not complete the discharge questionnaire; so these outcome statistics are based on clients who completed treatment.) Although our results are preliminary, we have found that 100% of clients demonstrated some overall symptom relief over the course of services. We have found that 89% of adolescents and 38% of adults demonstrated statistically significant symptom relief. As would be expected with an initially externally motivated adult population, it appears that many adult clients may not feel comfortable reporting negative symptoms during admission. This would be consistent with the clients' reports that they are often surprised that we are not going to label or judge them and the counselors' report that clients often become more open once they begin services. Unfortunately, this would result in a false low number of clients who demonstrate statistically significant symptom relief. These results indicate that SACP may benefit from reassessing when the clients should complete the initial OQ-45.2 or from administering the instrument more frequently throughout the course of treatment.

The remaining two evaluation methods derive from our clients' opinions. Our clients are in the best place to assess whether our approach is making a difference for them. We ask each client who completes our program to rate various aspects of our program on a scale from one to four (1 = poor, 2 = fair, 3 = good, 4 = great). A summation of this data is the third evaluative measure of our effectiveness. The clients' lowest average rating was a 2.9, and was in Schedule Convenience. All other areas were rated as a 3.3 or higher (see Table 2). The Social Services referred clients rated each category as equal or slightly higher to the non-Social Services referred clients. We were not surprised to have learned that the majority of all SACP clients (including the Social Services referred clients) listed Program Content as their first or second choice when asked what they liked best about our program (see Table 3). However, we were quite surprised to learn that many non-Social Services referred clients cited "education" as their first or second choice when asked what they liked least about SACP (see Table 4). When we did an item analysis to understand this response (since we do not offer formal education services), we learned that this group of clients was frequently referring to the one-time State mandated HIV/AIDS education component (which includes a demonstration and information

Table 2. Client Evaluation of SACP Services

	Non-Social Services Clients	Social Services Clients
Individual Counseling/Case Management	3.4	3.7
Program Content	3.3	3.4
Atmosphere	3.4	3.5
Counselor Professionalism	3.7	3.7
Schedule Convenience	2.9	2.9
Structure	3.3	3.5
Front Desk Staff	3.8	3.8

Note: 1 = poor, 2 = fair, 3 = good, 4 = great

on the effective use of condoms) when responding to this question. These client evaluations further revealed that the majority of clients believe that they completed their identified goals, would recommend SACP services to a friend, believe that the services they received at SACP have been beneficial, and that they have learned some skills during their treatment episode (see Table 5). Our clients tell us that this high level of client satisfaction is due to our willingness to work with them and to be respectful of their needs.

We recently asked our current clients to complete a survey to help us to measure how well we are meeting their needs. An analysis of this data is the fourth evaluative measure (see Table 6). Twenty-four percent of those who completed the survey were adolescents. Sixty-one percent of these clients were referred by Social Services; 14% were referred by the Jefferson County Juvenile Assessment Center; 9% were referred by either a parent, friend, self, or insurance company; 3% were referred by the Jefferson County Public School system; 12% were referred by the legal system; and 1% were referred by other external sources. We learned that 35% of our current clients report that they have received previous substance abuse treatment (40% of our current Social Services

Table 3. Client Evaluation of SACP Services (Like Most about SACP—First or Second Choice)

	Program Content (%)	Interaction with Peers (%)
Non-Social Services Clients	76	42
Social Services	75	32

Table 4. Client Evaluation of SACP Services (Liked Least about SACP—First or Second Choice)

	Urine Screens (%)	Schedule (%)	Education (%)
Non-Social Services	20	20	25
Social Services	23	36	9

referred clients report receiving previous substance abuse treatment). We then asked these clients how our treatment program compared with their previous experience. We asked them to rate their answer on a 10-point scale (1 = worse, 5 = same, 10 = better). The average response was 7.9. Seventy-eight percent of those who stated that they had received prior services, rated SACP services as a 6.5 or higher on this scale.

We were eager to learn what differences our solution-focused approach was making to our clients. We asked our clients how well we have done listening to their opinions and understanding their needs because if clients do not perceive that we understand their needs, our efforts to help will be ineffective. Our clients report that we have done well in this area (the average response was 8.3). We were curious about how comfortable our clients feel about asking for help in the future based on how they were treated at our agency. It would be naive of us to believe that our clients would not be in need of help in the future. It is our goal to increase the likelihood that these clients will reach out for help in the early stages of a future crisis. We were encouraged to learn that our clients report feeling very comfortable asking for help in the future (the average response was 8.5). Lastly, we asked them how much we have helped them to identify a goal that is important to them and to work toward that goal. Our clients report that we have done well in these areas (the average responses were

Table 5. Client Evaluation of SACP Services

	Non-Social Services Clients (%)	Social Services Clients (%)
Completed Tx Plan	94	97
Would Recommend SACP to a Friend	91	100
Services Have Been Beneficial	98	97
Learned Some Skills at SACP	91	87

Table 6. SACP 1999 Client Survey Results

	General SACP Population	Social Services Clients
[a]How does SACP compare to previous treatment received from other agencies?	7.9	8.1
[b]How well has SACP done listening and understanding client needs?	8.3	8.6
[c]How comfortable are the clients asking for help in the future based on their experience at SACP?	8.5	8.7
[c]How helpful has SACP been in assisting clients in identifying goals that are important to the clients?	8.1	8.4
[c]How helpful has SACP been in assisting clients to work toward those goals?	8.0	8.4

Note: [a]1 = worse, 5 = same, and 10 = better [b]1 = very poor, and 10 = excellent [c]1 = not at all, and 10 = very much

8.1 and 8.0 respectively). The clients rated SACP high on all areas of this survey (the lowest average response was 7.9). The responses given by the Social Services referred clients were consistently slightly higher to all of the questions on this survey (see Table 6). This may be due to the greater exposure that this population may have to other service providers who use a more problem focused approach.

CONCLUSION

The effects of substance abuse continue to ravage America. Radical legislative action has been and continues to be tried to curtail the impact on society. Although some "new" motivational treatment approaches are currently in use by some treatment agencies, they embrace the basic tenets of the "disease model." Many of these services are program based and do not take individual client need into consideration. Local public health in America has been given a daunting responsibility. We are charged to promote and encourage healthy behaviors and to assure the quality and accessibility of services. In addition, we are to "inform, educate, and empower people about health [including mental health] issues," evaluate the effectiveness of current services, and develop "innovative solutions to health problems" (Essential Public Health Services Work Group of the Core Public Health Functions Steering Committee, personal communication, 1998). The Jefferson County Department of Health and Environment, Substance Abuse

Counseling Program has accepted this role. We have created what we believe is an innovative solution to substance abuse that is based on research and that is making a measurable difference for our clients. We know that this is not the only solution to the problem of substance abuse. We as treatment providers need to get creative, look at what we know works, and take the risk to change what is not working. We need to think outside the box. We need to be evidence-based. We challenge all treatment providers to ask the questions, "How do I know this works? Where is my evidence?"

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