ALCOHOLISM TREATMENT AND
IMPLICATIONS FOR SOCIAL WORK

HONORS THESIS (499)

BY

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INTRODUCTION

Social workers are professionals who deal with multiple problems in diverse populations. They help the very young in child welfare settings, and the very old in health care settings. Social workers help the poor and the disabled, as well as those with psychological disorders. Truly effective social workers require knowledge in a wide variety of subject areas. One of the most prevalent problem areas social workers deal with on a daily basis is alcoholism. Although many professionals are not as educated as they might be about this disease, it involves social workers daily.

The purpose of this report is to ignite the interest of social workers to further educate themselves about alcoholism. This report is not intended to teach social workers everything they need to know about alcoholic clients or treatment of such clients. Rather, it is used as an introduction, or a place to begin the learning process.

The author begins by looking at the problem of alcoholism as it exists in our society. Definitions are investigated and expanded upon. Next, the service delivery systems that exist today are examined. State and national resources, employee assistance programs, community-based services, and alcohol treatment centers are also discussed.

The bulk of this study comes from information gathered through interviews of three inpatient alcohol treatment centers (ATCs), in comparison to a national study on ATCs. These centers were examined for the purpose of discovering the role of the social workers in these centers. Interview content is displayed in Table I, and expanded upon in a post table summary. Finally, the author discusses the implications for social work practice and education, according to the needs and resources identified in this report.
"Alcoholism is recognized as one of the most devastating social and health problems of contemporary life" (Krimmel, 1971). This devastation consumes about six percent of the population, or 12-14 million problem drinkers, bringing into the picture 53 million detrimentally affected family members (Dye, 1985). Furthermore, alcoholism, along with cancer and traffic accidents, is one of the leading causes of death in the United States (Kinney, 1983).

There have been numerous attempts by many different organizations to define alcoholism. Although these definitions all have slightly different characteristics, they all are based on the tenet that alcoholism interferes in some way with the adequate functioning of one's life. In the past, as was seen during the temperance movement, alcoholism was often viewed as a moral failing, or as a socially deviant behavior. However, the most recent research concludes that alcoholism is a disease, a chronic disease. While an acute disease is treated and cured, a chronic disease, such as alcoholism, remains for life. The intention of the treatment is to help one live in spite of the illness. Therefore, alcoholics are treated--alcohol is removed from their lives, and therapy begins by adding a more desirable replacement--so that they can live without further progression of the disease (Kinney, 1983).

In alcoholics Anonymous (AA), alcoholism is often referred to as "an obsession of the mind and an allergy of the body..." (Kinney, 1983). Once the alcoholic starts to drink, he cannot predict what will happen next. According to the World Health Organization, the alcoholic

"...shows notable mental disturbance or an interference with bodily or mental health, their interpersonal relationships and their smooth social and economic functioning..." (Krimmel, 1971).
Thus, alcoholism is not measured by the amount of drinking, but by how it affects one's life. No absolute rule of thumb can separate alcoholics from normal or heavy drinkers. Often alcohol quotient questionnaires are used to diagnose the disease. However, a clever alcoholic sees the intention of the yes/no questions and can answer in such a way to deny any problems with alcoholism. A more effective way of diagnosing alcoholism involves using the "big picture" approach, whereby physical exams, medical history, social history, laboratory tests, and clinical observations may be combined to get a more complete picture (Kinney, 1983).

In the past, alcoholism carried with it such a stigma that people denied and hid the disease in any way possible. However, there has been a gradual shift in the public attitude since the 1940s. People have discarded the "immoral, or socially outcasting" concept of alcoholism. Recent polls reveal that 80 percent of the population believe alcoholism is an illness (Kinney, 1983). Now that alcoholism is seen as a disease, and a medical problem affecting the whole family, many doors have opened up in helping areas such as medicine, nursing, and social work. For example, the Federal Government has focused on alcoholism as a major public health problem, and has helped to create treatment and educational programs.

**ALCOHOLISM SERVICE SYSTEMS**

Many service systems exist today to help the alcoholic and those affected by the problem of alcoholism. These resources exist on the state or national level, in places of employment, and in community-based service organizations. They take the form of educational or informational programs, as well as peer support, diagnostic, counseling, and treatment services.
STATE AND NATIONAL RESOURCES

The state and national resources are often used when community resources are not available, or appropriate for one's particular problem or situation. There are many state programs. For example, each state has its own department of alcoholism services, a government agency that is responsible for alcohol related programs.

The National Institute on Alcohol Abuse and Alcoholism frequently provides free information on alcoholism and drug abuse, as does the National Clearinghouse for Drug Abuse Information. The National Council on Alcoholism (NCA) is also a non-profit, national voluntary health agency. There are several hundred local affiliates of the NCA, which are very familiar with the problems of alcoholism. The NCA also provides free information on alcoholism, treatment resources, and counseling services.

EMPLOYEE ASSISTANCE PROGRAMS

Many companies have now adopted Employee Assistance Programs (EAPs). Although they only recently have gained popularity, as of the 1970s, they have existed since the 1950s. "EAPs are a structured approach for dealing with troubled employees whose poor job performance is costing the company money..." (Depner, 1985). The troubled employee is often an alcoholic employee. Through an EAP, an alcoholic employee can be referred to a treatment center, and can get the help he needs for recovery.

The employer of an alcoholic is an extremely important figure. The employer has a lever over the alcoholic employee--the threat of job loss, thus threatening the workers' economic security. If the alcoholic will seek help for no other reason, often he will seek it if his job is being...
threatened. For this reason, it is very important that employee supervisors and managers be educated about alcoholism, knowing which behaviors and attitudes on the job indicate the possible presence of an alcoholic employee. If the supervisor has reason to believe an employee is alcoholic, or having problems with alcohol, he can refer the employee for help, thus making treatment and recovery available.

COMMUNITY-BASED SERVICES

In addition to available state and national resources and employment-based services, most communities have many local resources that provide information or assistance to people for alcohol-related problems. Programs or services commonly available are highlighted below.

Information and Referral

Information and referral programs are resources existing in many communities. These programs may take the form of telephone hotlines or multi-service centers. They offer information for a variety of areas. Although they probably do not have in-depth information on alcoholism, they can refer clients to other, more appropriate resources. These programs frequently may be identified by looking in the telephone directories, under information and referral or alcoholism. In addition, County Health and Social Service (Welfare) Departments provide information on various community services, including those dealing with alcoholism.
Peer Support Groups—AA

The oldest and most successful of organizations to help alcoholics is Alcoholics Anonymous (AA). This fellowship was founded in 1935 by two alcoholics, Dr. Robert Smith and Bill Wilson, who found mutual support in each other as a last resort. The intention of AA is for peers to help one another. It is a voluntary organization open to anyone with a problem in his drinking behavior, who wants to quit drinking. It is regarded as the greatest single therapeutic tool in the treatment of alcoholism today. There are more than one million members in AA today. AA is also an important adjunct to many other treatment programs. For example, most alcohol treatment centers use AA quite extensively. In fact, 56% of ATCs have AA meetings within their facilities. Also, many of their alcoholism counselors are members of AA themselves. (Krimmel, 1971).

Al-Anon and Alateen are branches of AA that center on helping those family members or friends who are affected by the alcoholic’s drinking. These groups are structured and operate much like AA; however, their hope is to help people cope with the problems that arise from another’s drinking.

Counseling Services

Mental Health Centers and Family Service Agencies exist in most communities. They are excellent sources for referrals. Some of these organizations have counselors who are trained in alcoholism treatment and can provide direct treatment for alcoholics and their families. This is very important because alcoholism is a family disease. Spiritual counselors also provide help for alcoholism problems. They are often experienced counselors, and can refer clients to other treatment.
resources. Also, many religious organizations themselves sponsor or operate alcoholism treatment facilities.

MEDICAL SERVICES

Physicians are important resources when dealing with alcoholism, for they may be among the first to diagnose the disease. As alcoholism is more commonly recognized as a disease, the medical field may become more aware of its presence, and may take action more quickly when the medical warning signs first appear. However, not all physicians are yet knowledgeable about alcoholism, and one cannot depend on his physician to diagnose the disease in oneself or in another.

Most hospitals offer information about treatment, while many offer treatment services as well. Both private and public hospitals have alcoholism programs, as do Veterans Administration Hospitals. Many hospitals have either inpatient or outpatient alcoholism programs. Some also offer aftercare, outreach, and educational programs. Even emergency service centers can refer patients to treatment centers.

Alcoholism Treatment Centers

There are a growing number of specialized alcoholism treatment facilities in existence today. These facilities usually offer inpatient and outpatient programs in which the alcoholic can go through detoxification and recovery. The cost of these centers varies; and staff are usually highly trained, often specializing in alcoholism treatment. Although programs differ, alcoholism treatment centers do have many things in common, as found in a national survey of alcoholism treatment centers.
(ATCs) conducted by Joseph Boscarino, PhD, in the spring of 1978. Dr. Boscarino sought information from all facilities on the listing of the National Institute of Alcohol Abuse and Alcoholism; 396 centers (75% of all facilities) responded. The research revealed that ATCs averaged approximately 800 patients per year. Six out of ten centers provided medication for their clients; while the clinical modality most often used in ATCs was individual therapy, followed by group and family therapy. In addition, most programs use AA extensively, and 95% of all centers recommended use of AA to their patients. Many ATC alcoholism counselors were members of AA themselves (Boscarino, 1980).

The survey also revealed that 56% of all ATCs have inpatient beds available; the average capacity was 18 beds. In 1978, the average number of patients treated per year in inpatient programs was 308. The vast majority (roughly 80%) of all patients were male, and their average age was 45 years. The majority of persons served were low income, and the most common sources of referral were: criminal justice departments (22% of all referrals), social service agencies (15%), and the patient's family (12%) (Boscarino, 1980).

ATC staff characteristics were very uniform across the country. The largest group of professional employees was alcoholism counselors, followed by social workers and nurses. An average of three alcoholism counselors worked in the ATCs; while centers averaged 1.5 social workers and 1.5 nurses (Boscarino, 1980).

The following sections of this report will look more closely at the characteristics of three inpatient alcoholism treatment centers in the midwest and the role of the social worker in alcoholism services.
A STUDY OF
THREE MIDWESTERN ALCOHOLISM TREATMENT CENTERS

METHODOLOGY OVERVIEW

Specialized alcoholism treatment centers exist in many communities today. In order to learn more about services available to alcoholics and their families through these centers, as well as the role of social workers in alcoholism treatment centers, the author conducted face-to-face interviews with program staff of three inpatient treatment centers in the midwest. Site visitations were made during the winter of 1986 at Woodstock Memorial Hospital (WMH) in Woodstock, Illinois, Ball Memorial Hospital in Muncie, Indiana, and Richmond State Hospital (RSH), in Richmond, Indiana. All sites selected were in reasonable proximity to Ball State University. While programs selected for review represent only a small opportunity sample of existing ATCs, they provide a reasonable mix of programs in terms of facility size, catchment area, and clientele served. The author used an interview schedule whereby information was collected in a variety of areas, including: program content and services offered, clientele served, treatment center staff characteristics, and outcome measures of program success.

SUMMARY OF FINDINGS

Data obtained in the site visitations is summarized in Table I. As shown, there are clear differences as well as similarities between the three alcoholism treatment centers studied, particularly in regard to program content, client population, and program personnel. Findings in these areas will be highlighted on the following pages.
<table>
<thead>
<tr>
<th>SUBJECT:</th>
<th>RICHMOND STATE HOSPITAL (RSH)</th>
<th>BALL MEMORIAL HOSPITAL (BMH)</th>
<th>WOODSTOCK MEMORIAL HOSPITAL (WMH)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Designed for people who have already attended short-term programs. Six month average stay.</td>
<td>21-28 day stay.</td>
<td>21-28 day stay.</td>
</tr>
<tr>
<td>DETOX UNIT:</td>
<td>None.</td>
<td>Yes.</td>
<td>Yes.</td>
</tr>
<tr>
<td></td>
<td>Bridge detox unit on State Hospital grounds, but not connected with this unit.</td>
<td>4 detox beds available.</td>
<td>12 detox beds available.</td>
</tr>
<tr>
<td>COST:</td>
<td>$69 per day.</td>
<td>$147 per day.</td>
<td>$236 per day for detox.</td>
</tr>
<tr>
<td></td>
<td>No extra lab or doctor fees.</td>
<td>Extra lab and doctor fees.</td>
<td>$196 per day for recovery.</td>
</tr>
<tr>
<td></td>
<td>Less expensive because less medical emphasis.</td>
<td>Cost usually covered through clients' insurance.</td>
<td>Costs usually covered through personal insurance.</td>
</tr>
<tr>
<td></td>
<td>Client fees paid by the state, or occasionally through client insurance.</td>
<td>Client must have insurance to be eligible for program.</td>
<td>365 free beds are available each year for the indigent needing detoxification.</td>
</tr>
<tr>
<td></td>
<td>Clients are never declined for monetary reasons.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>PATIENTS:</td>
<td>BMH</td>
<td>WMH</td>
<td></td>
</tr>
<tr>
<td>----------</td>
<td>-----</td>
<td>-----</td>
<td></td>
</tr>
<tr>
<td>500 per year.</td>
<td>150 per year.</td>
<td>254 for the first year.</td>
<td></td>
</tr>
<tr>
<td>Average age is 26.</td>
<td>Average ages are 30s.</td>
<td>Average ages are 30s.</td>
<td></td>
</tr>
<tr>
<td>Lower socioeconomic status.</td>
<td>Mostly men.</td>
<td>Working class patients.</td>
<td></td>
</tr>
<tr>
<td>Admitted in later stages of disease.</td>
<td>Mostly caucasian.</td>
<td>Male to female ratio is 5 to 1.</td>
<td></td>
</tr>
<tr>
<td>90% male.</td>
<td>Married.</td>
<td>Married.</td>
<td></td>
</tr>
<tr>
<td>90% caucasian.</td>
<td></td>
<td>Middle, late stages of alcoholism.</td>
<td></td>
</tr>
<tr>
<td>57% are ages 21-30.</td>
<td></td>
<td>Caucasian.</td>
<td></td>
</tr>
<tr>
<td>85% are cross-addicted.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>53% legal income is $5000 per year or below.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>20% legal income is $5000-$10,000 per year.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Admission motivated by precipitating factor.</td>
<td>Admission motivated by precipitating factor.</td>
<td>Admission motivated by precipitating factor.</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>SOURCE OF REFERRAL:</th>
<th>BMH</th>
<th>WMH</th>
</tr>
</thead>
<tbody>
<tr>
<td>75% from court.</td>
<td>Most common referrals from employers, clergy, family members, doctors, friends, patient, and courts.</td>
<td>Most common referrals from patient, family, and employer, and family services.</td>
</tr>
<tr>
<td>13% from alcohol or drug detoxification center. (Short-term such as BMH or WMH).</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
RSH

Program: Disease concept followed. Alcoholism is an illness affecting the mind, body, and spirit. Non-medical orientation. Alcoholics Anonymous is encouraged.

3 parts of program.
A. Awareness (3-4 weeks).
   - To better understand self and one's problems related to alcohol.
B. Education program (4-6 weeks).
   - Lectures, films, tapes, self-help groups.
C. Habilitation program (6-16 weeks).
   - Group support, alternatives to alcohol, patients go into community.

Group and individual counseling provided.

BMH

Program: Disease concept followed. Alcoholism is seen in patterns of same-sex heredity, and affects 10% of the population. Very medically oriented. Program is very AA based. AA sponsor assigned while in program.

3 part program.
A. Inpatient program.
B. After-care program.
C. Education program.
   - Service clubs, PTA, scouts, youth groups are educated about alcoholism and the program at BMH.

Spiritual care counselor is an important part of program. Group and individual counseling provided.

WMH

Program: Disease concept followed. There are genetic and physiological differences among alcoholics and non-alcoholics. Very medically oriented. Very AA based. Patient attends 6 AA meetings per week. AA sponsor assigned while in program.

Program consists of education on alcoholism through lectures, process groups, group therapy, various patient growth oriented assignments. Family conferences. Employer conferences are helpful. Patient must give consent. Gives employer a lever to use on patient. For example, the employee must remain sober and perform well on the job in order to keep his job. Group and individual counseling provided.
**FAMILY INVOLVEMENT:**

**RSH**

Family is rarely involved.
Most clients have no family, or have family that does not care about them.
RSH serves entire state, making family transportation difficult.
Help is provided for any family member requesting it.
Al-Anon is encouraged.
Only 1 in 1000 families come in for full treatment.

**BMH**

Family is very involved.
BMH will not accept patients who refuse consent to their family.
Family week: Topics include
- Morn. Alcoholism as an emotional illness.
- Spirituality is the first thing to go.
- Family makes a list of things the alcoholic has done to them, and confronts the alcoholic.
- Tues. Study the disease concept. 10% of population has disease. Children of alcoholics miss childhood experiences.
- Thurs. Talk about roles.
  - Characteristics of adult children of alcoholics.
  - What is "normal"? Refer to groups (AA, Al-Anon, A.C.O.A.).
- Fri. Communication workshops.
  - "I" messages.
  - Build up spouse's self-esteem.
Family week is often very painful because the hurt and emotions of the past are rediscovered.
Family week starts the third week of the program. Patient goes home Thurs. of third week, trial basis.
Family week is essential to program.

**MH**

Family is very involved.
2 family groups per week.
Tues. Discuss disease concept with family members. Encourage Al-Anon and Al-Ateen.
Sat. Patient and family work together. Film and discussion.
Al-Anon guest speaker talks on effects on the family.
Sun. Patient and family attend an open AA meeting, where a recovered alcoholic tells his story.
Family can only be involved if the patient gives his consent.
AFTER CARE:

RSH

No aftercare.

BHH

Patient attends one group each week for 2 years. This group is strictly for program "graduates." reunion every 2 years. 300 people attended the last reunion. Families are expected to go to Al-Anon and Al-Ateen. Patient attends AA at least once a week, or cannot attend the aftercare program. Some referrals are made to half-way houses.

WCH

Provided through family services. This "Sobriety Support Group" meets for 12 weeks. All patients that complete the inpatient program are referred to this group. Counseling and assessment are done here. 30-40% referrals actually attend this group. Patients are also expected to attend AA meetings 5 times each week. Patient's environment is examined before leaving treatment center. If necessary, patient is referred to a half-way house after treatment.

SUCCESS:

RSH

55% patients do not finish treatment.
40% finish program.
20% are considered to be successfully recovered for the rest of their lives. These 20% have remained sober for the last three years.

BHH

Success rate is between 60-70%.

WCH

Success rate is 85%.
FOLLOW UP:

All patients are referred to outpatient centers in their home town. Survey is given 60 days after leaving the center. RSH staff are very active in AA, and see former patients in meetings. A more in-depth follow-up study is starting. Questions on the survey include:

- Are you going to an outpatient program?
- How well were you prepared for it?
- Are you recovering? Why? Why not?
- What is the problem?

Comments.

This survey is sent to the patient, his family, the outpatient center. Treatment is considered successful only if all three sources agree on the success.

90% of BMH's program is the follow up. It is made up mostly of support groups, as mentioned in the aftercare section. These support groups are mandatory.

Clients are called once a month for the first 6 months, then 2 more times at 3 month intervals. They are asked survey questions. If a phone contact cannot be made, a questionnaire is mailed out. The staff from BMH is also very involved in AA, and it's fairly easy to check up on clients that stay in the local area (as most do) to see whether or not they attend AA, and remain sober. Many clients return to the center to visit staff.

Questions on the survey include:

- Are you attending aftercare at Family Services?
- Is your family going to Al-Anon?
- Have you taken any drugs, drinks, in the past month? Amount?
- Do you have a spiritual program?
- Do you have any legal problems?
- Are you better, the same, or worse than last month?

Suggestions for next month concerning any problems.
STAFF: 51 staff members.
Staff: patient ratio is 1:2½
Active in community AA.
Some are recovering alcoholics.
Most staff have BAs.
2 Social Workers on staff.
Both are working toward their Masters degree.
Social workers' job responsibilities...
 - social assessments
 - group work
 - family work
 - paper work
 - daily staff meetings
 - liaison between business office and medical records departments of hospital
 - answering phones
 - supervising practicum students

13 staff members.
Active in community AA.
Some are recovering alcoholics.
Staff is highly trained.
All staff have some type of certification in counseling or alcoholism.
All staff have or are working toward their Masters degree.
All staff have previous experience in the field of alcoholism.
No social workers on staff.
Hospital social workers may be brought in for various situations, such as child abuse cases, or parenting skills.

15 staff members.
Staff: patient ratio is 1:3.
Active in community AA.
80% are recovering alcoholics.
Staff have BAs.
3 nurses and 2 counselors are available at any time.
Weekly staff meetings.
No social workers on staff of alcoholism program.
Hospital social workers may be brought in for various situations.
Program Content

Consistent with Boscarino's survey of ATCs cited previously, all three program sites studied follow the disease model of alcoholism treatment. Also true in both the author's study and the national survey, most programs incorporate AA in either their philosophy or their actual programs. As shown in Table I, BMH and WMH rely heavily on AA, while RSH uses AA in its program to a lesser extent. Families are very involved in the programs at BMH and WMH, also consistent with Boscarino's finding that family therapy is a common form of treatment utilized in alcoholism treatment centers.

Both BMH and WMH are short-term programs, three to four weeks in duration. Following intake, the patient goes through detoxification and then a short, intensive course on life without alcohol. Both group and individual counseling is provided, and patients may return to their homes in just one month. In contrast, RSH does not offer detoxification services: patients are required to be free from all chemicals prior to admission. This program is a long-term, six-month, living experience without alcohol, and is much less medically focused. Aftercare is not provided at RSH as it is in the smaller hospitals studied. It would be very difficult for such a large institution which serves the entire state to provide aftercare or follow-up services. Although all three programs require that patients be at least eighteen years of age, only WMH requires that patients come voluntarily. WMH also requires the patient's consent to family involvement.
Client Population

Most patients are not self-motivated in seeking inpatient care, but come to ATCs because of a precipitating factor. Some are being threatened by the loss of their job, while others are experiencing family or health problems. At BMH and WMH, the most common sources of client referral are employers, family members, clergy, doctors, and friends. In contrast, 75% of all RSH clients are referred by the courts; many of these persons have criminal histories of a serious nature. As shown in Table 1, the client population served by this ATC differs in many respects from the other ATCs studied.

RSH serves a predominately low socio-economic population, and approximately 75% of the patients at RSH have previously been through at least one short-term program, such as BMH or WMH, but have not maintained sobriety. Patients at RSH, a state-supported institution, usually do not have money or insurance to pay for their own treatment and have progressed much further in the disease process: the average RSH patient has been addicted for the years and the vast majority have multi-drug addictions.

While patients at RSH represent the diverse criminal population of an entire state, BMH and WMH clientele are more representative of their respective working-class communities. Patients in these centers are primarily caucasian, blue collar, family men. A possible explanation for the majority of male patients at all centers studied is the more accepting attitude in society for men to drink alcohol and, consequently, their need for treatment. Also, men do more driving, are arrested more often for DUI and, therefore, may be referred to treatment programs more often.
Professional Personnel

Recovering alcoholics are often involved in the treatment program of other alcoholics. This is found in all three centers studied. Although RSH and BMH have less recovering alcoholics on the staff, 80% of WMH's staff comprised recovering alcoholics. The staff at all three centers is very involved in AA.

Professional personnel in the three programs studied corresponds closely to the staff characteristics documented in the national survey. All three ATCs have more alcoholism counselors than any other staff members. The next most common professions represented in the centers are those of social worker and nursing. RSH employs professional social workers. While BMH and WMH do not have formally trained social workers on staff, they both have personnel that performs social work duties. These duties include intake, group and family counseling, social assessments, discharge planning, acting as a liaison with allied community services, and supervising agency intern students and volunteers. Therefore, a significant social work role exists in each of the alcoholism treatment centers. Perhaps personnel other than professional social workers sometimes fills this role or performs these duties because there are not enough social workers experienced in working with alcoholics or because social workers are hesitant to pursue these positions. The following section will look more closely at social work practice in relation to alcoholism treatment.
IMPLICATIONS FOR SOCIAL WORK PRACTICE AND EDUCATION

It is very important that social workers be educated about alcoholism. Clearly, anyone in a field directly related to alcoholism treatment needs comprehensive knowledge about the disease. However, ALL social workers need, at minimum, a basic understanding of alcoholism, because they may encounter more alcoholics than any other profession. The ability to recognize the disease and be aware of its implications on other social problems is very important.

Due to the variety of settings in which they work, social workers may have the greatest chance of helping the alcoholic and his family members to seek help. According to Bailey, an estimated 15-20% of all applicants to Family Service Agencies are experiencing a drinking problem related to job loss, physical abuse, debts, and concerns of children (Krimmel, 1971). Thus, many applicants come to these agencies for assistance with one of these problems, when a precipitating factor in the problem is alcoholism. Family service counselors need to be aware that alcoholism is a family illness and that alcoholic behavior dramatically affects the alcoholic, his spouse, and the children. The family’s behavior, in turn, affects the alcoholic’s drinking. This cycle is often referred to as the “family illness.”

Many recipients of public welfare also have alcohol problems. It has been noted that “Alcohol provides a way for the disadvantaged to cope with the intolerable conditions of living...” It may well be the easiest way to deaden the senses and feelings of inferiority and hopelessness (Krimmel, 1971). Estimates of the prevalence of alcohol abuse among welfare recipients range from a low of 14% in Massachusetts, to a high of 40% in Ohio (Krimmel, 1971). These figures underscore the fact that social
workers in public welfare agencies require knowledge about alcoholism if they are to effectively help clients with alcoholism and related problems.

Social workers in correctional fields are also confronted with alcohol problems. More than 40% of all arrests are related to drunkenness, 1.5 million for DUI alone—the single largest category of arrests (Krimmel, 1971). As a result, people spend time in jail. This time is an excellent opportunity not only to dry out the alcoholic, but to get the offender into treatment and support groups. Social workers in the probation field need to be cognizant of these opportunities and use them to help the alcoholic.

Medical social workers also serve alcoholics and their families. While, in one year alone 22% of first-time admissions were diagnosed as alcoholic, most of these patients were admitted for problems other than alcoholism, such as gastroenteritis and nervous disorders (Krimmel, 1971). Many more patients are admitted for problems that are the result of alcoholism, but the alcoholism is never diagnosed or treated. If the social worker is knowledgeable about alcoholism, he can link more of these patients to treatment services. For example, in one hospital a social worker invited alcoholic patients to a support group session. Many of the patients who attended these sessions while in the hospital continued their participation following their release (Krimmel, 1971).

However, since alcoholism is often referred to as a medical problem, some social workers may feel intimidated by their lack of both medical knowledge and access to medical facilities. The social worker may be unaware that holistic treatment can, in fact, be done in social service agencies.

While some social work agencies have discouraged involvement with alcoholics, leaving treatment up to “experts,” it is not feasible for workers to send the majority of alcoholics to such experts. There is
neither enough people nor money available for specialized agencies to treat all alcoholics. Therefore, social workers in all agencies must learn about alcoholism and be prepared to help affected clients in their own agencies. Thomas Plaul, a strong advocate of this theory, believes that general health and welfare agencies must be the sources of leadership for care and treatment of alcoholism. Although specialized agencies may contribute significantly to treatment, primary responsibility rests in the hands of the general agencies (Krimmel, 1971).

The fact that alcoholism is not isolated from other problems, but is often complicated by social, economical, psychological and medical problems, is a significant reason why social workers in general agencies must be prepared to treat alcoholic clients themselves. General agencies cannot rely on specialized agencies to alleviate all alcoholism problems. If general agencies ignore the problem, believing specialized ATCs will find and treat these clients, many alcoholics will never find help. Furthermore, specialized ATCs may not be equipped to handle problems other than the alcoholism, as the general agencies are trained to do.

Therefore, it is essential that all social workers have a basic understanding of alcoholism problems and treatment. The first step is the ability to recognize alcoholism. An alcoholic client needs to be detected early in the intervention process. When social workers assess new clients, a complete evaluation should be given, keeping in mind the possibility of alcoholism. If a problem is suspected, the worker either needs to begin intervention, or to refer the client to more appropriate available resources.

Social workers who work with alcoholic clients in either in a short-term or long-term capacity must be fully aware of the enabler role. As described by Kellerman, an enabler is one who fixes what
alcoholics mess up, thus making it easy for, or enabling, the alcoholic to continue drinking without ever coming face-to-face with the problem. As Kellermann puts it, the enabler sets up a 'rescue mission' for the alcoholic, saving him from the immediate crisis, and relieving the existing tension (Kellermann, 1980). Service professionals must understand the difference between those behaviors which protect the alcoholic temporarily and those interventions which truly motivate him to address his problem of alcohol abuse.

Further, according to Adelstein, when social workers treat alcoholics, they need to look closely at their own attitudes and needs, because working with alcoholics is so different than working with other clients. The social worker must be sure he is capable of handling difficult alcoholic situations. Social workers who treat alcoholics need to be concerned with their own needs and limitations. These needs include...

- One's own need for success, as it is obvious that recovery from alcoholism is marked by many frustrations, relapses, and failures.
- One's ability to meet the demands of extremely dependent persons, and not become either overwhelmed or rejecting.
- One's own ability to set realistic levels of aspiration in treatment goals for patient or client.
- One's ability to accept hostility and rejection and still maintain a supportive relationship (Krimmel, 1971).

As suggested above, social worker-client relationships are often different when treating alcoholics. The alcoholic is in desperate need of a warm, trusting, and accepting relationship. It is essential for the social worker to provide this. As early as the initial contact, the social worker should show his genuinesness and acceptance, because an established relationship is often the first step toward recovery.
However, even when a relationship between the social worker and the alcoholic client is based on trust and acceptance, many clients try to disprove alcoholism by testing their ability to control their own lives, including their drinking behaviors. Many alcoholics try to prove they can quit drinking whenever they want to quit. They become frustrated when they lose this control, yet they deny their alcoholism. Social workers need to be able to recognize and confront this denial, helping clients face reality. Clients need to be shown confidence and be taught to face their problems without alcohol. Thus, the client needs to learn a new life—a life of sobriety.

Removing alcohol creates a gap in the client's life that the social worker must help the alcoholic fill with constructive behaviors. For example, when a client is having problems with his children and is escaping through alcohol, perhaps the social worker could suggest that he and his wife get out of the house for a few hours. This is just one of many constructive ways to fill the gap created by removing alcohol. Unfortunately, many families—who fail to seek help until reaching the point of total chaos—finally seek help from a professional, only to be told that nothing can be done until the alcoholic wants, and asks for, help. Thus, the family remains in a state of chaos. Professionals, however, need to know that families can be, and need to be, helped even when the alcoholic continues to drink. It is very important for families to understand that every family member is affected by the drinker's disease.

In summary, because of the variety of settings in which they work, social workers may have the greatest potential for helping alcoholic clients. Social workers are key figures in the recognition and treatment of alcoholism in our society; and alcoholism is a major problem that will be encountered by the majority of student and professional social workers.
For these reasons, it is essential that schools of social work include content on alcohol abuse and practice intervention with this population in their curriculum.
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