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Prevent Recidivism in Charles County, Maryland

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Social Change Portfolio

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Contents

OVERVIEW

Keywords: recidivism, lifeskills training, inoculation, stage of change, social-ecological model

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Goal: The goal of this social change portfolio is to prevent recidivism by offering a six-month life skills group at the local Health Department in Charles County, Maryland. The long-term goal of this prevention program is to reduce recidivism in Charles County by 5% in one year.

Significant Findings: Charles County, is a populous county in the State of Maryland with limited resources for adults with arrest records related to substance abuse. There are currently no long-term structural or prevention programs to assist with reintegration. The recidivism rate in the State of Maryland is near fifty percent (Maryland.gov, 2020). The application of the social-ecological model assesses the risk and protective factors of this population. The Stages of Change Model and Inoculation Theory focuses on reducing said risk factors and increasing protective factors of this population to incorporate the prevention program, Botkin Lifeskills group. Empirical data demonstrates this approach renders a positive correlation in reducing relapse of unwanted behaviors, which in turn prevents recidivism (LifeSkills Training, 2019).

Objectives: Establish a Botkin Lifeskills group at the Charles County Health Department that utilizes peer experiences to develop life skills related to career and educational development. Incorporate the Stages of Change Model to foster self-exploration related to the nonlinear development of change. Incorporate Inoculation Theory to integrate gradual exposure of risk factors. Model programs that afford advantages for this marginalized population. Increase awareness of the stigma and inequity of this population within Charles County.

INTRODUCTION

Preventing Recidivism in Charles County, Maryland

It is not a secret that relapse is part of addiction. Within the United States, 40 to 60 percent of individuals will experience relapse (American Addiction Centers, 2021). Relapse can cause individuals to resume problematic behaviors and endure emotional, physical, and psychological pain that may result in death. Despite the statistics and knowledge surrounding relapse, there are limited resources within the local Charles County Community to foster sober living and long-term recovery. There are short-term rehabs and outpatient treatment centers, but transitional care and structure are extremely limited (Gemme, 2021). Community involvement provides both support and structure which will promote long-term recovery, prevent recidivism, and offer economic growth within the community. Recovery can only begin after treatment is completed.

PART 1: SCOPE AND CONSEQUENCES

Preventing Recidivism in Charles County, Maryland

Charles County, Maryland is a commuter town. Neighboring cities with flourishing economic opportunities provide most of the revenue produced in Charles County. The source of income in Charles County hinders the financial accessibility of the local state government to provide preventive care to local county residents. Charles County, Maryland is one of the most populated communities within the state of Maryland due to its proximity to surrounding cities such as D.C. and Baltimore (Gemme, 2021). In 2015-2017 Charles County had one of the highest rates of drug deaths in the country (Gemme, 2021). The Charles County community has

access to local treatment facilities, but the lack of prevention programs limits the longevity of treatment (National Institute on Drug Abuse, 2020). The absence of these programs has a positive correlation to relapse and recidivism (Gemme, 2021). Preventing relapse means keeping people alive and outside of institutions (National Institute on Drug Abuse, 2020). Treatment is prevalent in Charles County, but prevention is not.

Unfortunately, current events and lack of accessibility to preventative resources have further increased opiate overdoses within the state of Maryland as a whole. In 2020 there were 2,499 reported opiate overdose deaths in the state of Maryland (State of Maryland, 2021). Approximately 90 percent of all substance use fatalities involve opiates (State of Maryland, 2021). Due to the high rate of fatal overdoses, the data regarding the opiate epidemic is abundant. It is important to remain mindful that this is only one substance contributing to the relapse rates and substance use deaths. All substance use-related fatalities increased by 22.8 percent in the year 2020 in our nation (CDC, 2021).

Charles County received one of the lowest grants to help with substance use treatment despite it being one of the most populated counties (Gemme, 2021). The grant was used primarily for public outreach and community awareness. Educating the public on the death rate is not preventing relapse. The population can be treated repeatedly, but there needs to be a focus on preventing relapse to prevent recidivism (National Institute on Drug Abuse, 2020). Allocating funds towards prevention will reduce the costs of institutionalization and treatment by preventing recidivism to render economic benefit to the community (SAMHSA, 2008).

Recovery is a different lifestyle and requires maintenance. Many people confuse treatment and recovery. Recovery can only take place once the person has completed treatment (Gemme, 2021). Recovery requires stability and community support to prevent relapse.

Recovery is the act of regaining the things that were lost in addiction such as relationships, employment, financial stability, accountability, dignity, and pride.

When discharged from treatment and institutions, clients lack the structure and support to sustain recovery (Gemme, 2021). This transitional period causes many individuals to experience relapse. Relapse causes stigma to increase within the community as well as reduces funding for other areas in need. Individuals who constantly need treatment due to relapse are draining funds from the state.

Relapse increases recidivism as most arrests involve drug abuse violations (Federal Bureau of Investigation, 2017). The more individuals who are in active addiction in our community the more influx of drugs and dealing swarm the community. This puts our youth at risk for exposure to violence and drugs (Odgers et al., 2008). Chronic relapse is a financial burden that results in death and drains hope of recovery (SAMHSA, 2008). Providing prevention to the local community will increase protective factors to help build back a stronger community while reducing the costs of treatment and long-term incarceration (SAMHSA, 2008).

Allocating funds to a prevention group focused on living sober will help reduce relapse and recidivism. This group entails building both intrapersonal and interpersonal skills such as general communication skills, self-efficacy, consequential analysis, maintaining healthy relationships, creating healthy boundaries, and building self-worth. All while building life skills such as resume building, interview skills, applying for scholarships to pursue technical skills, budgeting and banking, and how to manage credit. These are skills needed to sustain healthy behavior changes during re-integration into society to prevent recidivism (SAMHSA, 2016).

The goal of this social change portfolio is to prevent recidivism by offering a six-month life skills group at the local Health Department in Charles County, Maryland. The long-term goal of this prevention program is to reduce recidivism in Charles County by 5% in one year.

PART 2: SOCIAL-ECOLOGICAL MODEL

Preventing Recidivism in Charles County, Maryland

When implementing prevention, it is critical to understand how factors outside of one's control may influence their decision-making, experiences, behaviors, and disposition (CDC, n.d.). This is when it is imperative to become more aware of the social and ecological factors in one's life. The primary population for this prevention portfolio is adults with an arrest record in the Charles County area who recently completed substance abuse treatment. When implementing the social-ecological model, it will assess the risks associated with relapse as relapse is correlated to recidivism (Dream Center for Recovery, 2016). This model will measure both risk factors and protective factors at the individual, relationship, community, and society levels. When implementing prevention, it is imperative to understand how these factors can influence each other at various levels.

The first component of the social-ecological model is the individual level. When exploring the population, adults with criminal records related to substance abuse there are unique experiences that put one at higher risk for relapse and recidivism. Individual risks of this population include a prior history of legal charges, history of relapse, history of trauma/abuse, impulsivity, mental illness, any physical pain or chronic medical conditions, and any genetic predispositions that may increase their exposure to addiction or mental illness (SAMHSA, n.d.). The previously mentioned factors can cause stressful stimuli and triggers in one's life (Department of Veteran Affairs, 2020). This does not negate the ability of one to remain clean

but may present additional challenges. Protective factors at the individual level of this population include exposure to recovery, existing religious/spiritual beliefs, willingness, positive mindset, and an individual with strong self-worth (NID, 2020).

The next component of the social-ecological model is relationships. Managing relationships in recovery is a daunting task. When exploring the relationships of this population, risk factors include unhealthy codependent relationships, socializing with individuals who use drugs, and violence in the home (The Recovery Village, 2020). One of the most challenging aspects of this social-ecological model is that this is asking the individual to leave long-term relationships to protect one's sobriety. This can be family or friends. For some people, this is the only exposure to support they have known, and now there is a form of blind faith to trust someone else to show you how to live. Protective factors in relationships include support networks and if the individual has any responsibility to family, pets, or career endeavors (SAMHSA, n.d.). If willing, these protective factors allow the individual to maintain positive relationships and structure in their life. Typically, protective factors in this model are based upon the individual's willingness to try something new. This is when it becomes important that the person is willing and values the opportunities that recovery affords.

The next section in the social-ecological model is community. Community is a huge part of recovery. Community refers to the network within Charles County. Charles County is a populated community with limited access to resources (State of Maryland, 2021). This creates a lower socio-economic class which limits employment, funding for schools, and funding for government agencies. These factors hinder the ability to pursue gainful employment, accessibility to resources, and increase exposure to crime. Charles County is in proximity to two large cities where drugs are prevalent, this makes drug use more prevalent in the area (Drug

Enforcement Administration, 2021). Exposure to substance use normalizes it within the communities. Protective factors of communities include close-knit communities (SAMHSA, n.d.). This means there is the accessibility of resources, community-based activities, and faith-based activities (CDC, n.d.). Charles County has pockets of close-knit communities, and they tend to be more rural areas. These areas utilize public community centers to foster opportunities for homing the homeless as well as various sports activities (Charles County Government, n.d.-b). Communities are beneficial when the structure is afforded to the individual. This structure provides purpose in one's life and instills pride and responsibility within the community.

Society is the final component of the social-ecological model. The pockets of poverty previously identified as close-knit communities and protective factors at the community level are risk factors at the societal level. This risk factor instills a negative connotation of stigma surrounding impoverished close-knit communities within society. The limited funds within our network hinder society's growth. Local residents experience a lack of financial stability as many economic opportunities are only available outside the local community and require readily available transportation. Lack of economic opportunity is a risk factor, which is prevalent in Charles County. It is difficult to definitively define a protective factor at this level. Society affords the opportunity for rehabilitation and treatment post-release from incarceration. The State of Maryland processes roughly 3,500 court orders annually that commit defendants for mental health and substance use evaluations (Maryland Department of Health, 2017). This is a protective factor of society in the social-ecological model. Unfortunately, within the Charles County Community there is limited efficacy supporting these efforts. This is where the problem lies. Our law enforcement system is currently not preventing crime as recidivism continues to rise (Maryland.gov, 2020).

The recidivism rate in Maryland in 2019 was near 50% in post-program releases (Maryland.gov, 2020). Treatment is healing, and recovery is maintenance (Gemme, 2021). Recovery requires the acquisition of new life skills to sustain a new way of life. After analyzing the social-ecological model within Charles County, one of the biggest flaws is the lack of prevention resources for transitioning adults. This affects all components of the social-ecological model (SAMHSA, 2016).

PART 3: THEORIES OF PREVENTION

Preventing Recidivism in Charles County, Maryland

Treatment has ended, but prevention is an ongoing cycle in the continuum of change among adults with arrest records related to substance abuse. Preventing recidivism in Charles County is directly correlated to preventing relapse. Relapse encompasses the idea of resuming unwanted, negative, and problematic behaviors (Gemme, 2021). The positive correlation between relapse and recidivism requires individuals of this high-risk population to continue executing life skills without the presence of problematic behaviors. The stage of changes model is a theory that is used frequently in preventing substance use among adult populations. The ideology creates a continuum that change is gradual while increasing personal self-awareness (National Cancer Institute, 2005). Implementing the stage change model in conjunction with the ideology found in inoculation theory will render positive results in implementing an accessible prevention-based program in Charles County, Maryland. The primary prevention model used in this prevention plan is stages of change, and the secondary is the inoculation theory.

The stages of changes model, also known as the Transtheoretical Model (TTM) was developed by Prochaska and DiClemente in the 1970s (National Cancer Institute, 2005). The

focus of this model is on the decision-making of the individual and the idea that change is not linear; it is gradual and continuous (National Cancer Institute, 2005). TTM has six total stages: pre-contemplation, contemplation, preparation, action, maintenance, and termination. This model is unique as the individual can enter and exit at any stage (National Cancer Institute, 2005). Pre-contemplation is the stage where there is no desire for change and the individual is ignorant to the behavior and the cause-effect relationship on their life (National Cancer Institute, 2005). The contemplation stage is the beginning change of healthy behaviors, but the individual is ambivalent to change (National Cancer Institute, 2005). The preparation stage is a short period when the person is willing and prepares to make small steps towards sustaining change (National Cancer Institute, 2005). The action stage is when the person has begun changing their behavior. This can be the process of modifying consequential behaviors or acquiring new behaviors (National Cancer Stage, 2005). The maintenance stage is when the individual has sustained the behavior and works to prevent relapse to earlier stages (National Cancer Institute, 2005). The final stage is termination which is when the individual no longer has a desire to return to unhealthy behaviors (National Cancer Institute, 2005). The uniqueness of this model is that it applies to any behavioral changes a person is experiencing and does not require the individual to work in a specific order.

The goal of this prevention plan is to prevent recidivism in Charles County. The individuals comprising this population have recent experiences with legal institutionalization and treatment. This means that they have completed a treatment program or some form of incarceration with treatment. The uniqueness of the stage change model is the individual is free to continuously work through the cycle (LaMorte, 2019). It increases personal self-awareness by no longer focusing solely on the problem but on how to acquire the skills to prevent the problem

(LaMorte, 2019). It provides a visual aid for understanding where one is and where one would like to be moving forward.

This population has sustained healthy behaviors from inside a bubble. They were isolated from triggering stimuli such as people, places, and things. Re-integrating into society is where instability and relapse of old behaviors become risky and there are limited protective factors for this population. There is pre-existing stigma, financial instability, hopelessness, lack of self-worth, limited supports, and lack of life experience (SAMHSA, n.d.). Chronic institutionalization often results in limited exposure to life. The population is no longer engaging in unwanted behaviors, but due to isolation, they fail to conceptualize the fallacy of problematic behaviors. Implementation of TMM allows fosters intra-self-awareness of the problem to prevent relapse to previous stages. More treatment is not going to aid these individuals in changing their attitudes and decision-making skills. The mind is clear of substances, so now begins the work of prevention to fulfill a healthy lifestyle of autonomy, competence, and relatedness to prevent problematic behaviors (Hodge et al., 2012).

This is when it becomes imperative to equip the population with the necessary life skills to further progress in the TTM and sustain a meaningful life. The TTM suggests there are ten processes to move throughout the change model (National Cancer Institute, 2005). These ten processes all require social awareness and acceptance. These ten processes include consciousness-raising, dramatic relief, self -reevaluation, environment reevaluation, social liberation, self-liberation, helping relationships, counter conditioning, reinforcement management, and stimulus control (National Cancer Institute, 2005).

The ten processes of TTM allow individuals to move from one stage to the next. The uniqueness of these processes is the acquisition of decision-making skills, self-reflection, self-

advocacy, and integration of assertive confidence that is occurring (LaMorte, 2019). These ten processes foster the beginning of protective factors to prevent both recidivism and relapse (SAMHSA, n.d.).

When implementing the proposed prevention program, there will also be a focus on the inoculation theory in guiding through these processes. The goal of the inoculation theory is to explore consequential social issues, which parallels the proposed prevention plan to prevent recidivism. This theory was developed by William McGuire (Matusitz & Breen, 2013). Traditionally, inoculation has been used in youth settings to help alleviate social pressure. Recent studies indicate that inoculation theory has rendered successful in reducing behaviors that lead to recidivism such as relapse (Matusitz & Breen, 2013).

Inoculation theory highlights that resistance to persuasion and influence requires exposure to weaker attacks. The theory models a similar approach to protecting the body from disease or virus (Matusitz & Breen, 2013). There is pre-exposure to a weakened version of the inevitable future threat (Matusitz & Breen, 2013). The idea is to strengthen existing attitudes to reject temptation before the stimuli are present. Applying inoculation theory to the population and stage of change model exposes individuals to the risk factors of their individualized life. This means there is an exploration of what it would mean to re-engage in triggering environments. A unique component of the inoculation theory is that it does not promote avoidance, rather the theory encourages pre-exposure. Inoculation theory prevents relapse of unwanted behaviors by equipping individuals with the assertiveness and attitude to confront threatening situations with confidence.

The stage of change model is a traditional long-term model of prevention that has been utilized in the development of multiple prevention programs as it applies to the change of any

behavioral modification (National Cancer Institute, 2005). The model is renowned for its ability to adapt to the complexities of change which is of value when presented with clients with low stability, such as the ones found in this plan (Velasquez et al., 2005). The structure of the model assesses the individual's readiness to continue adaptation to attain self-efficacy and decision-making skills. The theoretical orientation of the model is beneficial to the prevention of relapse as it readily assesses one's willingness to facilitate a behavioral modification. Its modality is person-centered and is focused on the readiness of the individual (Velasquez et al., 2005). The inoculation theory was chosen in the implementation of this prevention plan because despite limited research studies it has indicated it is effective in a high-risk population. It promotes new attitudes and counters counter-attitude persuasion (Matusitz & Breen, 2013). Inoculation's goal is to prevent criminal behavior that leads released prisoners back to prison (Matusitz & Breen, 2013).

When integrating TMM and inoculation theory within this evidence-based prevention program, it is imperative to recognize the population being served. This population is high risk and has limited supports. Incorporating a life skills group will increase protective factors and prevent recidivism. Life skills will focus on qualities that reduce the risk factors of this population. This includes a stable foundation for a support network, exposure to recovery, a positive mindset, self-worth, communication skills, both intrapersonal and interpersonal relationship skills, career development tools, budgeting skills, and a desire to fulfill a meaningful life (SAMHSA, n.d.).

In 2001 a manual was developed by Velasquez, Maureer, Crouch, and Diclemente that applied both the stages and processes of change into group settings for substance abuse. The focus of the groups is moving through the stages of change by focusing on the ten processes of

change (Velasques et al., 2005). Interestingly, TTM is partially modeled at the Charles County Department of Health when treating individuals with substance use disorders (Charles County Department of Health, 2021). This integration of the TMM framework allows individuals to transition to appropriate levels of care modeled loosely on the continuum of change. The current substance use groups focus on individuals who are currently using and guide the individuals from ambivalent feelings of change to motivation and determination. Unfortunately, the TMM model at the local health department ceases after the person sustains a short period of abstinence. There are currently no groups offering skills to increase protective factors among high-risk transitioning adults entering the maintenance stage.

Botkin Lifeskills training (LST) is an evidence-based program that has rendered positive results among adolescents (LifeSkills Training, 2019). LST is one of the top-rated substance use preventions in the nation (LifeSkills Training, 2019). Of note is that the skills acquired in the training not only reduce substance use but additional risky behaviors that may cause recidivism. This includes a reduction in physical aggression, verbal aggression, delinquency, and fighting (LifeSkills Training, 2019). Implementation of the LST group at Charles County Health Department will provide additional protective factors for this high-risk population while maintaining the already implemented theoretical model of TMM. The focus of the life skills group is centered upon continuing to maintain positive behavioral changes outside of institutional settings to prevent recidivism.

The evidence-based practice of LST focuses on healthy alternatives to risky behaviors (LifeSkills Training, 2019). LST is unique as it does not focus on the education aspect of substance use, rather the LST is focused on resisting social pressure, developing self-esteem/confidence, utilization of healthy coping skills, consequential analysis, and enhancing

both cognitive and behavioral competency to prevent health risk behaviors (LifeSkills Training, 2019). The three skills acquired are summarized as drug resistance skills, personal self-management, and general social skills (LifeSkills Training, 2019). The skills afforded in this group reduce at-risk factors and increase protective factors when re-integrating into society. The focus of the life skills group highlights the goals of preventing unwanted behaviors as discussed in both the TMM model as well as the inoculation theory.

The fallacy of the LST program is the limited efficacy with adults. However, when working with adults with arrest records related to substance use, institutionalization and incarceration often hinder the acquisition of life skills. Additionally, there may be a limitation due to other existing risk factors such as mental illness, trauma, cognitive impairments, limited economic opportunity, and limited family support (SAMHSA, n.d.). These risk factors all hinder the ability to make informed decisions. Despite LST programs being used primarily for adolescents, the skills acquired in this group are meaningful outside of the adolescent population and have rendered positive results for years post-adolescence (Lifeskills, 2019). Since the primary population of LST implementation is adolescents, a modification to the LST program would be the integration of career skills, educational exploration, resume building, and career development within the community. Fulfilling vocational endeavors is a vital protective factor in preventing recidivism and increasing community cohesion and economic opportunities (SAMHSA, n.d.). Traditionally, LST is a brief module varying from 10-30 sessions. However due to the risk of the population and the complexities of change within the TMM model a minimum of six months would be recommended for this population (Hodge et al., 2012).

TTM provides a structural framework for envisioning where one is in the continuum of change in a gradual and nonlinear progression. Implementation of a life skills group at the health

department continues the existing module of treatment while integrating the prevention that is lacking within the community. The LST practice fosters this module of prevention by promoting the integration of healthy behaviors to maintain a healthy lifestyle (LifeSkills, 2019). The systemic approach of inoculation theory collectively integrates with developing a new social perspective of attitude and how to confront confrontation. Implementing a life skills group at the health department with the integration of TTM, inoculation, and LFT will prevent recidivism by focusing on providing protective factors and an opportunity for self-awareness to continue sustaining the new healthy behaviors that were adapted while in treatment.

PART 4: DIVERSITY AND ETHICAL CONSIDERATIONS

Preventing Recidivism in Charles County, Maryland

Culturally relevant prevention poses a need when reflecting on the population at hand, adults with arrest records related to substance use. One of the most influential aspects of culture in this population is race. African American males have the highest rate of recidivism in our nation. In the United States, African Americans make up about a sixth of the total population and one-third of the prison population (Skinner-Osei & Osei, 2020). This trend is relevant to the Charles County community as well. In 2019, African American males had the highest rate of recidivism in the State of Maryland (State of Maryland, 2019). African American males are incarcerated five times more than white males (Sentencing Project, 2016).

African Americans demonstrate higher rates of willingness to engage and complete treatment programs, however, there is still a higher rate of recidivism among black Americans (Skinner-Osei & Osei, 2020). Incarceration and recidivism affect the black community negatively. It instills negative stigma related to incarceration as well as limits economic

opportunities (Skinner-Osei & Osei, 2020). This leaves the question how does one prevent recidivism amongst the African American population?

Based on the above-stated facts one can say affirmatively that African Americans are receiving both treatment and punishment, yet something is still causing high rates of recidivism among this population. The prevention interventions need cultural relevance and support (Reese & Vera, 2007). Within the health department behavioral health division at Charles County there are no male clinicians. When implementing the life skills group, it would be beneficial to have it facilitated by an African American male. It is easier to build rapport among individuals who have similar experiences related to beliefs, race, and upbringing (DeCuir-Gunby, 2020). This allows the group members to recognize that the facilitator likely has seen and experienced the world that they have. Additionally, the evidence-based practice approach of a life skills group needs to utilize interventions catered to the population. This means interventions of prevention should be based on values, beliefs, and desired outcomes of the black community (Reese & Vera, 2007).

While re-evaluating risk factors related to oppression, African Americans typically face more frequent incarceration with larger sentences (Skinner-Osei & Osei, 2020). This influences one's ability to cope with trauma. There is a predisposition to violence due to the exposure of prison culture within an institutionalized environment. This leaves the question of how does one prevent recidivism among the black community when pre-exposed to violence, limited economic opportunities, and negative stigma?

Implementing a cultural worldview has rendered positive effects in prevention programs (Reese & Vera, 2007). Worldview helps to eliminate bias within prevention programs. Unfortunately, racial disparity exists due to mismatching values in interventions and the community (Reese & Vera, 2007). This poorly hinders behavioral patterns. In order to

effectively utilize a cultural worldview as a prevention mechanism, one must know the community (Reese & Vera, 2007). This requires positive relationships with community members and an understanding of community values. What one may believe is an insight into how one is living, maybe nothing more than an inaccurate representation of the community. This is when it is important to listen, instead of assuming (Sirolli, 2012). It is okay to be wrong, if one is willing to learn. Develop the initiative to acquire a working knowledge of the community and how to connect members to opportunities (Reese & Vera, 2007).

Implementing a cultural worldview suggests a holistic approach in helping prevent recidivism from a more culturally competent standpoint (Skinner-Osei & Osei, 2020). Creating a cultural worldview allows one to see the person as a whole, rather than just one part. The CARE approach has four components collaboration, amend, reintegration, and empowerment. The uniqueness of this approach is the focus of the community within the individual. Collaboration emphasizes personal relationships with positive messaging (White, 2021). Amend encourages the reforming of policies to encourage post-incarceration (White, 2021). It additionally focuses on minimizing within the community by promoting economic welfare in terms of both housing and employment (White, 2021). Reintegration connects recently released individuals with justice-involved community members to bridge the connection of employers. This helps to negate stigmas and further opportunities within the community (White, 2021). The final component is empowerment. The empowerment component is coming to fruition as the results of the previous stages of the model result in a more inclusive environment (White, 2021). The CARE approach helps to incorporate community outreach, which provides an additional protective factor and prevents stigma within the community.

Ethical Considerations

As a counselor, one needs the ability to see the world from a new perspective. This can be a tall order for any clinician as life experiences have instilled a personal moral compass, values, and beliefs. This is when as a clinician there must be an awareness of what is right for oneself may not be right for someone else. According to the American Counseling Association (ACA) Code of Ethics, "A.4.B. Counselors are aware of and avoid imposing their own values attitude, beliefs, and behaviors" (ACA, 2014, p. 5). This ethical code suggests clinicians become aware of how their own culture does not intersect and influence the goals of future clients. This can be challenging. As clinicians, we have a desire to help others, and in helping others there needs to be both a boundary and an awareness in that our aspirations for our client may not be their journey or in their best interest. Over-exerting personal values hinder a client's autonomy and can inhibit growth. Our lens of life experiences distortion through unique journeys, experiences, and mistakes.

Cultural sensitivity requires humility. We can learn about cultures, but when we become experts about whom we believe our clients should be is dangerous. ACA Code of Ethics standard E.5.B states, "counselors recognize that culture affects how client's problems are defined and experienced" (ACA, 2014, p. 11). This suggests that each client's experiences and perspective of their problems are unique to them. Assumptions about how they should feel or perceive the problem are speculation. As clinicians, we walk beside the client when exploring the problem instead of assuming how the client perceives their problem.

There is no cookie-cutter solution to providing culturally sensitive prevention. What may work for one client, may not work for another. The counselor's ability to adapt to the unique needs of the client is a fundamental skill of a competent clinician that benefits the client's

longevity and quality of life. As counselors, we must focus on the needs of the population (DeCuir-Gunby, 2020). When reflecting on the recidivism of African American males, focusing on culture relevance/support and a cultural worldview in prevention evidence-based program will allow a platform of exploration and constructive feedback to better serve the black community.

PART 5: ADVOCACY

Preventing Recidivism in Charles County, Maryland

A well-known component of becoming a clinician within the mental health community is advocacy. Advocacy is an opportunity for clinicians to work within the community and overcome barriers of a specific population to help institute positive social change and prevention. The central component of advocacy is multicultural and social justice competencies.

The Multicultural and Social Justice Counseling Competencies (MSJCC) were originally Multicultural Counseling Competencies (MCC) (Ratts et al., 2016). However, MSJCC was found to better represent the evolving multicultural and social justice components within our society (Ratts et al., 2016). The goal of MSJCC is to provide a structural framework of how to address the numerous identities within the therapeutic relationship (Ratts et al., 2016).

MSJCC uses quadrants to highlight how power, privilege, and oppression influence interactions (Ratts et al., 2016). Quadrants allow reflection of how identities impact the counseling relationship. The domains are progressive levels of competence (Ratts et al., 2016). The idea of the domains is to focus on counselor self-awareness, client worldview, counseling relationship, and counseling and advocacy interventions (Ratts et al., 2016). Domain progression

is dependent upon the understanding of how various levels of barriers influence clients' unique experiences.

Competency is a vital component to implementing MSJCC competencies. Competency requires continuous development of attitudes, beliefs, and skills that allow the counselor to work with the client (Ratts et al., 2016). Competency development is embedded in the domains listed previously (Ratts et al., 2016). Advocacy varies according to the population and problem and a counselor's competency should reflect this constant evolution. When advocating for adults with criminal records related to substance use, one must have a thorough understanding of the socio-cultural barriers to develop interventions that represent this population. Sociocultural barriers exist at the institutional, community, and public policy levels.

Social institutions within a society may implement regulations or policies that yield disadvantages for this marginalized population. These disadvantages are institutional-level barriers (Murray & Crowe, 2016). This means agencies or institutions implement laws or policies that limit opportunities based on criminal backgrounds. Specific barriers include challenges with attaining occupational licenses, limited access to higher education institutions, limited access to public housing, difficulty obtaining financial loans, policies of not hiring convicted criminals, and background checks that hinder employment opportunities (Umez & Pirius, 2018). These barriers contribute to the risk factors of isolation, lack of economic opportunity, and lack of financial stability. These policies may not sound like a huge influencing factor in recidivism, but once one is released from incarceration employment is a requirement of probation/parole (Hall et al., 2015). Inability to fulfill these requirements may result in reincarceration. After reviewing the barriers of this population, advocating may require a needs assessment. This assessment is contingent upon the client's response as well as the counselor

conducting research of the opportunities of the privileged versus this marginalized population (Murray & Crowe, 2016). As an advocate, it would then be in the population's best interest to seek institutions that provide advantages for this population. The idea is to use empirical data to support the implementation of these programs in other institutions (Crowe & Murray, 2016). For instance, our local IBEW Union 26 offers African American males with felon records accelerated opportunities for employment (IBEW 26, 2015). This program helps alter the inequality among this population by affording opportunities to this marginalized population. Acquiring relative statistics for fellow businesses may render positive change within local institutions (Murray & Crowe, 2016).

MSJCC competencies at the community level focus on norms, values, and ways of functioning within society (Murray & Crowe, 2016). As a competent counselor working in this population, it is important to explore how they see their personal role within their community. Adults with arrest records related to substance use are stigmatized in society (Moore et al., 2018). This stigma is likely influenced by the repetitive patterns of recidivism and norms within society (Moore et al., 2018). Unfortunately, stigma can cause negative perceptions towards oneself. Internalizing stigma is detrimental to functioning (Moore et al., 2018). Self-value lowers and one begins to envision themselves according to how lowly one believes their community views them. This can raise risk factors of poor self-image as well as becoming withdrawn in the community. These risk factors have a positive correlation to risky behavior that in turn may result in recidivism (Moore et al., 2018). Interventions at this level require social advocacy (Murray & Crowe, 2016). The idea is to explore how the norms, values, and regulations in society hinder the growth of adults with arrest records related to substance use. Creating awareness within the community among both the privileged and marginalized

population helps to squash stigma. Awareness allows both parties to envision how the traits of society hinder and contribute to marginalized populations' growth and development (Murray & Crowe, 2016). Exposing stigma is a huge component of MCSJCC. This form of advocacy could take place at local community events to help bridge the connection between marginalized and privileged persons (Murray & Crowe, 2016). The idea is facilitating an opportunity to hear the concerns of the public as well as inform the public of the negative impact of stigmatizing behaviors. It is important to hear the public's concern to better understand how to reduce the stigma related to criminal offenses (Murray & Crowe, 2016).

The public policy level of barriers is the local, state, and federal laws impacting this population. Specific barriers related to the public policy level include felons losing their right to vote, limited access to government bases, a focus on punitive punishment rather than rehabilitation, and revocation of driver's license (Hall et al., 2015). Losing the right to vote among this population means that upon release from incarceration, they do not have the privilege to participate in policymaking like the rest of society. This results in a consequence of being denied a civil right, an additional consequence of social reintegration (Hall et al., 2015). The interesting component to the barriers of the public policy is the limitations they create for the population. Removing one's driving privileges again hinders the ability to obtain employment and access to community resources. When reflecting on the recidivism rates in the state of Maryland, it is clear punitive punishment is ineffective (State of Maryland, 2019). Yet, lawmakers continue to incarcerate repeat offenders and reduce access to resources for re-entry into society. Advocacy at the public policy level requires social justice. For instance, "Minnesota, voters with a criminal record were one-half as likely to be rearrested as those with criminal records who did not vote" (Hall et al., 2015 p. 66). This punishment of dismantling a

civil right has had the opposite intended effect. This punishment correlates to an increased chance of recidivism. Studying and analyzing public policies and the correlation of recidivism is imperative in understanding the limitations of this population. Competency as a counselor at this level requires policy reform to create inclusion. A counselor may seek direct communication with legislatures to reform the integration of recently released individuals from incarceration (Murray & Crowe, 2016). The current policy dismantles opportunities for this marginalized population.

I wish to highlight the importance of public policy's influence on the community and institutional level barriers. Imagine a three-tiered pyramid, the public policy level is at the peak of the three-tiered pyramid. The laws and policies developed percolate down the pyramid into all other sections. It directly influences the community and institutional barriers. It is messy. The regulations of public policy directly impact all other barriers. This leaves the question; how can one be re-integrated into society when public policy strips a civil right of a reformed offender who has served time? Is retribution a lifelong process? Why would the community see a peer as equal when this peer cannot vote, access government bases, or is unable to possess a driver's license? If the state sees this person as unfit, why should the rest of society think otherwise? Why should institutions hire individuals who our nation does not see fit to have a civil privilege? This leaves the final question if no one else believes offenders can change, why would offenders try to change? Advocacy for adults with arrest records related to substance use needs reforming originating at the policy level. Society idolizes what is taught at a public level. In order to advocate for this population, there needs to be a focus on creating accessible opportunities for reintegration into society (Hall et al., 2015).

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