Women with substance use disorders (SUD) of abuse or dependence offer particular challenges for treatment clinicians and other social service professionals. Women with SUDs often have multiple needs or problems in areas such as housing, employment, health, mental health, and family. Additionally, for mothers with SUDs, parenting responsibilities often present obstacles to treatment attendance and compliance. This is especially problematic if the mother is involved with child protective services (CPS). Often mothers present for substance abuse treatment to fulfill a legal mandate in order to reunify with their children. In any case, the responsibilities of raising dependent children present real obstacles to substance abuse treatment adherence.

This article will present some of the challenges facing drug abuse treatment providers and other professionals working with mothers who have SUDs and are caring for dependent children. The issue of drug abuse treatment adherence will be discussed, along with the factors specifically affecting adherence for substance abusing mothers. Finally, some strategies will be offered to improve treatment adherence with this population.

Substance Abuse Treatment Adherence

High rates of treatment dropout make it critical to identify effective interventions to improve adherence. Adherence is an active process of collaboration with an agreed upon treatment plan. Poor adherence manifests in a number of ways including missed appointments, delay in seeking treatment, failure to abstain from substances, and not completing therapy tasks or other requirements of the treatment plan (Daley and Zuckoff, 1999). Reasons for poor adherence are numerous, but there are special circumstances that must be considered for women. Particularly for mothers, dependent children provide real challenges that professionals must be aware of. Three areas are especially difficult: parenting in the early phases of recovery, parenting with special needs children, and parenting while negotiating legal system involvement.

Continued on page 2 . . .
Continued from page 1 . . .

EARLY RECOVERY PHASES
AND PARENTING

Early recovery phases include the initial engagement in treatment along with stabilization of substance abuse symptoms (Daley and Thase, 2000). In this stage, one of the main challenges for mothers is learning to parent their children while also beginning to learn a new healthy lifestyle. A number of issues become potential treatment challenges.

Learning new parenting styles:
Families develop certain habits and interaction patterns. In addicted households these patterns are often unhealthy yet difficult to change. Children learn to behave in certain ways that serve to support the unhealthy system yet become problematic in recovery. Learning to counteract these old patterns becomes a significant challenge for parents.

Negotiating roles: In substance abusing households, family members take on roles to support the addiction. Children may assume parenting roles to substitute for lack of a parent figure. These roles become threatened when the addicted parent becomes sober and tries to act as head of the household.

Seeking support: Many substance abusing mothers are single parents who must rely on extended family supports. This can be a double edged sword because extended family members are sources of help but often are highly critical and distrusting due to past behaviors during the mother’s active substance use. This can lead to the mother feeling undermined while trying to re-establish herself as a responsible parent.

Interpersonal relationships: The role of significant others (e.g., fathers or boyfriends) is often difficult to negoti-}

ate. An active male influence can be a source of support and encouragement. However, many mothers are involved with negative or absent male influences. These relationships, which are often highly discordant and sometimes violent, can affect parenting and the emotional reactions of children. In extreme cases there are fears for the children’s health and well being due to ongoing substance abuse and/or violence by the significant other. Such issues have a large impact on treatment adherence.

For example, a young single mother was raising her son while trying to stay sober after an inpatient rehabilitation stay. When the father was released from jail, he came to live with the mother and son. The mother had previously been attending outpatient treatment consistently, working on her own recovery and learning behavior management techniques for her son who exhibited oppositional and social anxiety behavior. When the father came back, the mother’s attendance became more sporadic and she frequently did not show for sessions. Further exploration revealed that the father was actively using cocaine and verbally abusing the mother in front of the child. Attempts to engage the father were unsuccessful and there was no evidence of child abuse so a childline could not be sought. The mother eventually dropped out of treatment, stating that she was moving to a new location.

PARENTING SPECIAL NEEDS CHILDREN

Children of substance abusing mothers often have emotional and mental health needs of their own that need to be addressed. Often due to discordant upbringing from living in a substance

abusing household, abuse, neglect, or domestic violence, these children tend to exhibit more anxiety, depression, and behavior problems (Bukstein, 1995; Galanter and Kleber, 1999). Additionally, children who are prenatally exposed to drugs or alcohol are at high risk for emotional, developmental, cognitive, and behavioral problems (Wetherington, Smeriglio, & Finnegan, 1996). The special treatment and parenting needs these children require can be extremely stressful on a mother who is trying to recover from substance abuse.

Older children and adolescents also present special and challenging problems when a mother first begins a recovery lifestyle. Older children may have been the caretakers of the family while the mother was actively using substances. When the mother enters recovery and tries to reestablish herself as caregiver, there may be tension and animosity between the mother and older child. The older child, who may have been independent, now finds the parent trying to set appropriate rules and boundaries. The older child may resent this new pattern thereby increasing conflict and stress on the recovering mother. In some cases the older child may have developed substance use problems and, in the case of teenage girls, begun experimenting with sexuality often leading to pregnancy. The recovering mother now must deal with the pressures of being a grandmother in addition to other life stressors. Recovering mothers and teenage daughters frequently conflict over these and other issues.

For example, a mother had been struggling with her own recovery and relapse patterns for many years. During that time her teenage daughter became pregnant. The stress of dealing with her teenage daughter increased because the daughter was always worried about the mother and dealt with her feelings
by acting as a critical parent, constantly criticizing and checking up on the mother in an effort to keep her involved in her life. The mother interpreted this behavior as demeaning and was ashamed, which increased her stress and desire to use drugs. As the daughter’s pregnancy came to term, the conflicts increased due to both parties feeling increased burden of the responsibility of a baby, and the interaction patterns increasingly became more negative. The mother became so overwhelmed she dropped out of treatment and went on a four-day crack and alcohol binge.

**NEGOTIATING THE LEGAL SYSTEM**

Mothers with SUDs frequently become involved in the child protective system (CPS). This is usually precipitated by an anonymous phone call from a third party or during the delivery of the baby at a hospital. If the baby is delivered with drugs in his/her system, the hospital will contact CPS, often leading to the removal of a baby from the mother. Once this occurs, the mother must work with the system in order to regain custody and keep her child(ren). Usually the requirement includes a drug and alcohol evaluation and treatment.

Mothers who enter mandated treatment due to CPS involvement are typically angry, hurt, ashamed, and distrustful of any authority figure. Many mothers have histories of trauma, abuse, neglect, and domestic violence (Wetherington and Roman, 1998). Being forced into treatment and having their control stripped away is experienced like another form of abuse. Mothers who have educational or intellectual deficits and/or mental illness find themselves ill equipped to work within the system to get their children back. These mothers usually resist the system and defeat their own purposes, thereby losing their children in the process.

Many mothers who lose their children must negotiate with foster parents or other legal guardians around visitation, parenting, and role disputes. Role disputes, regarding who has the legitimate right to parent, often leads to conflicts between natural parents and legal guardians. For the mother trying to stay sober, this adds additional stress and pressure that increases the risk for relapse.

These are just some of the issues mothers with SUDs must cope with when they begin to engage in a recovery program. Finding ways to improve adherence is essential given the high dropout rates and the negative effects dropping out of treatment has on the spectrum of life domains, including parent-child relationships.

**Educational Interventions**

Many mothers enter treatment not understanding the process of treatment or distrusting that the counselor has their best interest in mind. One way to improve adherence is to educate the patient on the treatment/recovery process. This would include psychoeducational information about the illness that the patient presents with, a description of the treatment process, and a discussion about the role of the treatment center in providing services to court mandated patients. By explaining the roles and requirements of fulfilling that role, the patient gains greater clarity on what treatment can and cannot do. Providing direct feedback about the treatment process, patient progress, confidentiality, and legal mandates for court reporting (e.g., results of drug screens and treatment attendance), provides the patient with a clear guideline as to what to expect from treatment.

Continued on page 4 . . .
is a greater likelihood that the client will see the treatment as a helping agent rather than a punitive measure.

Motivational interviewing (Miller and Rollnick, 1991) is also well suited for women because of its client-centered nature and support of self-efficacy. Motivational strategies acknowledge the real life stressors that contribute to symptom formation and validate the woman’s experience while supporting the belief that change is possible. In that sense it becomes a strength-based intervention that is more likely to instill hope and therefore improve adherence in substance abusing women.

**CLINICAL INTERVENTIONS**

Clinical interventions refer to efforts by a therapist or other professional to engage a client through outreach and consumer service. Examples include the use of letters and phone calls to engage a new client or to re-engage a client who has missed sessions or dropped out. In discussing missed appointments or noncompliance with a treatment plan, it is important to convey concern and empathy to the client’s life situation and take a problem solving approach regarding obstacles to adherence. Providing feedback about progress and engaging the client in the review of treatment goals can facilitate hope, problem solving, and motivation.

Substance abusing women, especially those involved in the legal system, receive very little positive support regarding their efforts. By showing interest in their life situation and conveying respect, the therapeutic relationship is enhanced and more productive work may be accomplished. Providing feedback lets the woman know where she stands and what areas may need further intervention. It is important that the treatment goals be client driven (i.e., determined by the client with guidance from a professional) rather than directing the mother to a prescribed treatment. Otherwise it seems as if the woman is enduring the same treatment as in the legal system.

**SYSTEMS INTERVENTIONS**

Systems interventions include case management, advocacy, and integrative treatment procedures. The multiple needs of some mothers call for comprehensive treatment programs that include prenatal and neonatal care, family therapy and involvement, parenting skills, vocational training, medical services, HIV prevention, and child care services. Standard individual drug treatment has typically forced the mother to rely on her own resources to meet these needs. However, women who do not get these needs met are at risk for treatment dropout. Child care is one factor that is of particular concern, especially for welfare-to-work mothers who are required to go to work but have no provisions for child care. Lack of adequate child care often leads to treatment drop out (Wetherington and Roman, 1998).

Wrap around services have been used for substance abusing mothers with high risk children. Wrap around interventions include in-home services, community interventions, and professional psychiatric/psychological services. Such services provide extra support for women with high risk children by focusing on multiple areas of functioning for children such as school, home, recreation, medical, legal, mental health, and others.
Monitoring Adherence

Once a mother is engaged in treatment, it is important to be aware of warning signs indicating a risk for dropping out of treatment. Warning signs that a mother is noncompliant with treatment, and potential intervention strategies, include the following:

**Indicators of Poor Compliance**
- Missing treatment sessions.
- Late for sessions.
- Failure to work on goals.
- Failure to complete assignments.
- Missing self-help meetings.
- Failure to take medications (if prescribed).

**Counseling Strategies**
- Discuss current compliance problems immediately.
- Help the client anticipate roadblocks to change.
- Negotiate rather than dictate treatment plans.
- Discuss pros and cons of self-help and treatment assignments.
- Address anxiety about treatment, self-help, or medications.
- Monitor relapse warning signs.

*(Daley and Zuckoff, 1999, pp. 19 and 82)*

**Summary**

Drug and alcohol treatment providers and other professionals must consider the special needs of mothers with substance abuse problems in order to increase the chances of successful treatment entry and improved adherence once treatment has been initiated. Many mothers drop out of treatment because they are overwhelmed with the responsibilities of being a parent along with trying to negotiate the challenge that substance abuse recovery creates. Having a nonjudgmental and problem solving attitude where the goal is to understand the unique needs of an addicted mother can increase motivation for treatment. Treatment programs should be designed to support parenting needs. This may include child care, special treatment services for children, parenting education, and other services such as housing and employment.

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**REFERENCES**


**UCSF Family Alcoholism Study**

A study being conducted at the University of California, San Francisco is using the most advanced technology to attempt to find genes for alcoholism.

The UCSF Family Alcoholism Study is currently seeking families for its research. The researchers are looking for people who:
- have had a problem with alcoholism;
- have at least one sister or brother, or both parents, who would also be willing to participate; and
- have not had an addiction to another substance, except nicotine, marijuana or caffeine.

The study takes about four hours to complete and can be done by mail and phone from anywhere in the country. If you participate you will:
- be asked to complete paper-and-pencil personality tests;
- have about 4-5 tablespoons of blood drawn;
- respond to an interview about substance use and medical history; and
- be reimbursed $30-$50, depending on the amount of time and effort required.

If you are interested in participating, or would like to learn more about the study, call the researchers at: 1-888-805-UCSF (8273) or visit their website at: www.familystudies.com

*All information is kept strictly confidential.*
Few programs are designed specifically for drug dependent pregnant and/or parenting women, and evaluations on these programs are even rarer. Addiction treatment programs were originally designed for men and were expanded to serve women despite gender differences (Metsch et al., 1995). This approach, of course, has fundamental flaws since women are inherently different from men.

As a result, women seem to face barriers in addiction treatment which are exacerbated when they are pregnant or parents of dependent children (Ettore, 1992). There is also evidence to suggest that pregnant and parenting women face numerous obstacles when attempting to access treatment services (Grella, 1996). It has been estimated that 200,000 to 500,000 children are born to drug addicted women annually (Seroncini, 1996), but less than 35% of those women seek treatment (SAMHSA, 1997). Women also have lower rates of treatment entry and program retention compared to men (Wallace, 1991). This underutilization may be due in large part to the paucity of substance abuse treatment programs tailored to meet the specific needs of pregnant and parenting women.

The defensive structure of an addicted incest survivor needs to be respectfully addressed rather than eliminated or ignored in recovery. Too often addiction professionals perceive defense mechanisms as character defects rather than abuse after-effects. Many addicted incest survivors are confronted to reduce their level of defensiveness and denial in order to change their addictive behaviors, cognitions, and feelings. This traditional treatment philosophy based upon “the disease model” contradicts the feelings and behaviors exhibited by addicted incest survivors. Therefore, incest is misperceived and remains unaddressed, which in turn contributes to placing addictive survivors in vulnerable positions for premature program discharges and addiction relapses. All of these treatment problems intensify when women are either pregnant and/or parents of dependent children.

Biopsychosocial Model

While no single form of treatment is effective for every drug dependent individual, a biopsychosocial perspective may be more suitable for women. Practical applications based on this philosophy may allow women to address issues that have been previously ignored during treatment. For instance, women may be more likely to disclose issues of physical, sexual, and emotion-
Such an understanding of this relationship is necessary for the development of a comprehensive theoretical model that will promote improvements in the quality of addiction treatment for women.

**Biopsychosocial Treatment Program**

In 1988, the Diagnostic Rehabilitation Center of Philadelphia developed the Hutchinson Place (HP) program to address the needs of low income, culturally diverse, drug addicted pregnant and parenting mothers of preschool children. The goals of HP are to promote a drug-free lifestyle and to break the cycle of continuing abuse through developing and sustaining supportive relationships. To this end, the program has implemented an intensive treatment approach based upon the biopsychosocial model. Issues within each mechanism (biological, psychological, and social) are addressed in treatment through integrative services. All of the women and their children are matched with specific interventions and treatments based upon their individual biopsychosocial needs (see Table 1 on page 8).

Treatment consists of assessment and evaluation, individual, group, family, and psychoeducational modalities within a nine-month period, and aftercare and follow-up services after program completion. Women work through their issues at their own pace and are continually evaluated clinically as they accomplish specific goals during each phase of treatment.

**Evaluation Design**

An evaluation was conducted to explore the direct and indirect relationships among childhood abuse, biopsychosocial factors, alcoholism and other drug addictions, and program retention. Clients were volunteers from Hutchinson Place. Between August 1998 and April 1999, 53 clients completed self-report surveys within their first 30 days of treatment. The survey included seven questionnaires containing items that assess familial alcoholism/addiction, childhood abuse, self-esteem, social support, family support, belief systems, mood states, coping methods, and substance use.

Continued on page 8 . . .
### TABLE 1

**Biopsychosocial Assessment and Treatment**

<table>
<thead>
<tr>
<th>DOMAIN</th>
<th>SUBDOMAIN</th>
<th>CONTENT OF INTERVENTION</th>
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<tr>
<td><strong>BIOLOGICAL</strong></td>
<td>Medical</td>
<td>Past medical and physical illness</td>
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<td>Family medical and past illness</td>
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<td>Current medical and physical problems</td>
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<td>Current medications and compliance</td>
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<td>Pre/post-natal care</td>
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<td>Health prevention for children</td>
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<td>Health risk behaviors</td>
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<td>HIV prevention and health education</td>
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<td></td>
<td></td>
<td>Physical and gynecological exam</td>
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<td></td>
<td></td>
<td>Mental status exam</td>
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<td><strong>PSYCHOLOGICAL</strong></td>
<td>Mental Health</td>
<td>History of diagnosis and treatment</td>
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<td>Family history of mental illness</td>
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<td>Diagnostic evaluation</td>
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<td>Attitudes</td>
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<td>Affective</td>
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<td>Behavioral</td>
<td>Current substance use</td>
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<td>Drug history and treatment history</td>
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<td>Familial drug use history and treatment</td>
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<td>Prevention relapse for high-risk situations</td>
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<td>Ways of coping</td>
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<td>Childhood Trauma</td>
<td>Sexual Abuse</td>
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<td>Domestic violence, adult abuse, rape</td>
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<td>Legal and/or custody issues</td>
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<td>Sentiments of culture</td>
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Evaluation Findings

DEMOGRAPHICS

The majority of participants were African-American women with at least two dependent children with them in treatment. The average age of the women was 35 years and at least half of them had previous treatment. Of these women, 77% reported crack-cocaine use and 46% of them also reported alcohol abuse. Over half of the women reported being treated for a co-occurring psychological disorder. Sixty-five percent of the women used prescription medication daily and almost half of them used over-the-counter medication weekly. In addition, 79% of the women reported a combination of two or more types of childhood abuse. Half of the women reported having an alcoholic family member and 62% of them reported being raised in a non-traditional family structure. All of the women were homeless and receiving some type of public assistance.

PREDICTORS OF TREATMENT SUCCESS

A series of hierarchical regression analyses were conducted to explore the direct and indirect relationships among childhood abuse, biopsychosocial factors, and program retention. Program retention was defined as the number of days in treatment. Results from the analyses support that childhood abuse directly predicted the length of stay in treatment. This finding suggests that women who have experienced at least one type of abuse may be likely to stay in treatment longer than those who have not experienced abuse. Although this finding is based on a small sample of women, anecdotally abused women have little esteem, lack physiological needs such as food and shelter and lack psychological needs such as trust and safety. Therefore, these women may be more likely to stay in a program that provides such nurturance.

Childhood abuse was also indirectly related to program retention by mediating factors of affective beliefs, coping methods, and mood states. Childhood abuse directly predicted both affective beliefs and coping methods. Affective beliefs directly predicted mood states, and in turn both mood states and coping methods predicted program retention. The results from these analyses suggest that women who are more cognitively focused are more likely to use constructive coping methods and self-regulate their affective states which in turn increases the likelihood of completing treatment.

Mood states and coping methods are known to be precipitating mechanisms for relapse (Marlatt, 1987). However, the majority of the women in this study were diagnosed with a psychological disorder and taking medication for this condition. It is probable that this psychological/medication factor led this particular group of women to make better decisions regarding their treatment. In fact, medication usage directly predicted program retention. This result suggests that this group of women may have been more successful in treatment because they were identified and treated for a co-occurring condition. Integrative treatment may lead to better retention rates for this particular group considering that these women had previous treatments that solely focused on substance use.

Another interesting finding was that a history of physical abuse also predicted treatment success. Women with a history of physical abuse may be more likely to stay in a residential program out of fear of returning to an abusive relationship or environment. Implications from these findings suggest that women who have been physically abused may have better treatment outcomes, since they reap the rewards from staying in the program longer.

The number of children also predicted treatment success. Results suggest that women with fewer dependent children outside of the program are more likely to stay in treatment. Evaluation results also found that women with two children with them in treatment were more likely to complete treatment than those with more than two children with them in treatment. Implications from these results support that women with dependent children outside of the program divide their attention between their children, which in turn places them at-risk for premature program discharge. While these women are likely to leave treatment prematurely, so are women with more than two children with them in treatment. Women with more than two children may not be able to focus on lessons learned and may be at increased risk for relapse. In addition, women with adult children may stay in treatment longer. Adult children may serve as a form of positive family support, which in turn may enhance the length of stay in treatment. Family support did not predict program retention directly but it was related to previous treatment failures and childhood abuse. Implications from these findings are two-fold in that childhood abuse promotes poor family relationships, and lack of family support mitigates treatment success and failure. Overall, these results suggest that women with dependent children who have a history
of abuse may adjust to the structure of a residential program, make lifestyle changes, and stay in treatment longer than those without such experiences.

**PREDICTORS OF TREATMENT FAILURE**

Preliminary path analyses revealed that childhood abuse inversely and directly predicted substance use. Childhood abuse also predicted mediating factors of family support, social support, self-esteem, coping methods, affective beliefs, mood states, and avoidance beliefs. Specifically, childhood abuse led to family support, self-esteem, coping methods, and affective beliefs. Family support directly led to social support, while affective beliefs led to mood states. Mood states and coping methods both directly predicted avoidance beliefs and avoidance beliefs led to substance use. Coping methods and social support led to substance use. The results from these linear relationships suggest that childhood abuse is more likely to predict substance use when mediated by psychosocial factors as described above. One possible explanation is that childhood abuse may be more likely to lead to program retention among this particular group of women. Another explanation is that each particular type of abuse contributed to other mediating factors such as physical neglect and emotional abuse. Physical neglect was linked with coping style, while emotional abuse was linked with family and social support. It seems as if the type of abuse may positively and directly predict substance use. Maternal alcohol use and sexual abuse both predicted treatment failure. These results suggest that particular types of abuse lead to specific psychosocial factors, and, in turn, these factors predict treatment outcome. Sexual abuse was also linked with affective and avoidance beliefs which in turn were associated with substance use. Implications from these findings suggest that sexual abuse leads to substance use which serves as an avoidance coping method, while emotional and physical abuse lead to protective factors that promote resilience and constructive coping methods. In addition, emotional abuse was also linked to medication usage, family, and social support. Physical neglect was linked with coping methods. Medication usage, support levels, and coping methods were all associated with successful treatment. These analyses suggest that the interaction among biological, psychological, and social factors precipitate either treatment success or failure among drug-dependent women who have children and histories of childhood abuse.

**Conclusion**

Implications from these findings suggest that factors from biological, psychological, and social paradigms should be addressed in treatment in order to understand the coping process of drug-dependent women with histories of childhood abuse. Program development and evaluation should focus on treating drug-dependent women with children from a multi-system point of view. Future investigations should incorporate rigorous evaluation methods for biopsychosocial and gender-specific models.

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**REFERENCES**


This article describes the benefits and challenges of teaching parenting skills to parents who have a history of alcohol and drug problems. It is based on four eight-week parenting classes conducted for parents in drug and alcohol treatment programs (two outpatient, two inpatient) over a one-year period. Parents’ primary concerns were: “How do I explain my addiction to my children?” “How do I deal with my children’s anger and resentment?” “How do I deal with my guilt of having subjected my children to my addiction?” “How do I include my children in my recovery?” “How will I convince my children I will stay clean?” “Will my children become addicts like me?”

Parenting and support class helped parents think about these issues and work through them as a part of their recovery process. It also helped raise parents’ consciousness and competence to deal with the issues that will arise over the coming years of their recovery.

**Introduction**

Alcohol and drug abuse affects a parent’s ability to parent appropriately. Parents with an alcohol or drug problem are typically required by the court to attend parenting classes for reunification with their children or other child welfare purposes. The basic parenting classes that are offered to these parents usually do not address the issues of their drug and alcohol problems and the difficulties that they will have reuniting with their children. Many parents complete mandated classes and still do not know how to deal with their children and their guilt.

**Parenting the Second Time Around for Parents in Recovery** is an eight-week parenting class based on the 12-Step model with information about child development. It was designed to help parents process issues with regard to their children and develop realistic expectations of the children’s development and adjustment to reunification. The class focuses on facilitating the parents’ efforts to change their behavior, attitude and thinking.

**Target Population**

The class was designed for biological parents who have a history of drug and alcohol problems, and who are in treatment with at least 30 days clean (those with psychiatric illness were excluded). At the start of the first group, 60% of the participants’ children were in the custody of a relative, although 50% of these children had lived with their parents throughout their parents’ addiction. The remaining participants had children placed in foster homes by the court. The ages of the children ranged from infants (six months) to teenagers (seventeen). Parents in the class had been separated from their children for an average period of five months. During the course of the parenting class, 35% of the parents had their children returned to their custody. Many of the participants from the residential treatment center had their children living there with them.

The majority of the participants from all the classes were African American. The average number of parents that attended each group was fifteen. Of the 50 parents who graduated from the classes, 7 were fathers and the rest were mothers. Their ages ranged from 25 to 40 years old, and the average length of stay in treatment was one year. Most of the parents came from multi-problem families characterized by poverty, lack of education, poor health, abusive childhood and disruption in parenting, including foster care placement. Many of the parents were raised in families with a history of alcohol and drug problems.

**Identifying the Parents’ Concerns**

At the initial meeting of the class, each parent was asked to write about his or her major concerns about parenting. Most of them revealed that they had not been consistently parented themselves or were raised in a dysfunctional...
Continued from page 11 . . .

family. The majority had similar concerns about parenting their children after a history of drug and alcohol use. Parents also acknowledged their poor parenting during their addiction and inadequate parenting since entering recovery. Many of the parents felt they needed to learn how to deal with their children’s behavior and how to make up for the time they did not spend with their children. They also expressed concern about how to regain their children’s respect. Most parents felt their children should automatically respect them but quickly learned that respect is earned over a period of time and requires much work and patience.

Curriculum

The curriculum was designed to address some of the common concerns of parents with a history of alcohol or drug problems. It focuses on the following issues:

- **Being a parent in recovery** – dealing with child’s resentment and anger, how the parent’s alcohol/drug use affected their child, changing themselves not their child, working the 12 Steps around parenting, and seeing how the process works.

- **Historical influences** – Parenting within their family and similar parenting practices.

- **Discipline** – Self-discipline, the effectiveness of discipline the parent received as a child and the parent’s methods of discipline, and looking at new methods.

- **Single parenting** – Balancing children with recovery activities and other activities, including self-care.

- **Myths about parenting** – e.g., the parents know what they are doing, and the child’s behavior is the parent’s fault.

- **Building self-esteem in your child** – Positive strokes, communication/trust, and spending special time together.

- **Support Systems** – Developing new friends and identifying positive support.

Each topic has worksheets for the parent to complete with sample questions such as: “What do you regret most that you did to or around your child during your addiction?” “How are you dealing with it?” “Since you have stopped drinking and using, what changes would you like to make in your parenting?” and “How well do you deal with your child’s feelings around your addiction?” The worksheets are designed to help the parents to look at themselves honestly and to enable them to discuss some of the problems they may have being a parent with a substance abuse problem.

At eight weeks, toys (e.g., paints, jacks, coloring books, crayons, stickers, and bubbles) are provided for the parents. They get the opportunity to play. Many parents with a history of alcohol and drug problems started using alcohol and drugs at such an early age that playing was not something they did regularly. As a result, many of them did not know how to play with their children. Allowing the parents to play teaches them playing skills to use with their children.

Challenges of the Parents

Parents trying to learn about parenting face many obstacles. One of the most serious obstacles is trying to stay clean and sober and parent their children. Some group members initially need to focus primarily on recovery from addiction; for these parents, taking on parental responsibilities is a slow and gradual process (Plasse, 1995). For so long they ran from their parental responsibilities by drinking and using; to face these responsibilities without using is difficult for them.

Another obstacle that parents face is not being able to complete all the tasks (e.g., treatment, parenting, anger management) that agencies require them to complete in a short period of time (usually six months or less). Because of these many things that have to be completed, the parent may become overwhelmed, which may lead to relapse. Another challenge is parents’ fear of looking at past parenting skills; some are not able to face their past head on so they may get defensive about taking suggestions.

Strategies to Help Parents

The most effective instructor for a “parenting in recovery” class is a Drug/Alcohol Counselor with a child development background. This instructor is more likely to understand the recovery issues that may arise and the challenges parents in recovery face, and also offer realistic information about the child’s development. The facilitator can give suggestions to the parents to help them understand how to deal with their children’s behavior. Suggestions may include:

- Guilt you have about your addiction and past parenting can be motivation for change, but do not allow guilt to control your present.

- In order to effectively discipline your child, you must be disciplined within your own life and recovery.
Always be honest with your child about your capabilities and remain open to their feelings.

It is okay to admit you are wrong to your child; you do not have to be perfect.

It also is helpful if the class is taught at a residential or day treatment facility where the parents receive an array of other services such as individual and group counseling and 12-step meetings.

Challenges of Teaching Parenting to Parents with a History of Alcohol and Drug Problems

In teaching the class, the instructor encounters some obstacles reflective of the parents’ lack of trust and fear of being judged by the instructor and the other parents. For so long these parents could not trust anyone because of their lifestyle. Being in treatment does not mean they immediately start to trust. It takes time and patience on the instructor’s part to gain their trust.

Debra had been in outpatient treatment for a little over sixty days when she started the parenting class. Debra has three children—a daughter, Kenya (11), and two sons, Darron (6) and Mark (4). Her major concern was her relationship with her daughter. Debra said that since she started her drug/alcohol treatment, Kenya had become angry and defiant. Debra could understand what was causing this behavior, especially because since she entered treatment, it has allowed Tanya more time to do things most eleven years old want to do (e.g., playing with her friends and going to the movies). Indeed nothing Debra did seemed to please Kenya; she only had negative things to say, and when mom asked what the problem was, Kenya would just say “nothing.” Debra was at her wit’s end with this behavior. When she brought the problem to the class, Debra was asked, “What was Kenya’s role in the family during your addiction?” Debra explained that Kenya took care of household chores and was basically the parent to the younger siblings and even sometimes to Debra herself. However, after entering treatment, Debra resumed the parenting role and her relationship with Kenya became troubled.

As the instructor, I explained to Debra that her daughter’s reaction was typical. Children who assume the role of the responsible person during the course of the parent’s addiction often become angry when the parent gets in treatment and takes back the responsibility without preparing the child for the change. Debra has to remember that Kenya does not understand why she is no longer able to continue being the responsible person. As a parent Debra needs to try some of the following suggestions to help Kenya with the transition:

- Recognize and acknowledge Kenya for all her hard work.
- Communicate with Kenya through all the changes (do not assume she understands).
- Help Kenya adjust to the changes.
- Be honest, consistent, and patient with Kenya during the process.
- Encourage Kenya to talk about her anger.
- Seek counseling.

After practicing some of these suggestions, Debra reported that although she was still having problems with Kenya, they were making progress and the situation was improving.
Continued from page 13 . . .

Benefits of the Class

At the end of the eight weeks, the parents are asked to complete a questionnaire. They have a chance to explain in their own words the benefits of the parenting class. Responses to the question, “What have you learned most from this class that you had not learned from other parenting classes?” included:

- A mother of three children and four months in treatment answered, “I have learned to include my children in my recovery by explaining to them what is recovery and what I am able to realistically do as a parent.”
- A mother of one teenager with three months in treatment answered, “I have learned that I will not convince my child I will stay clean by just telling her, I have to make changes in my life and stay consistent with the changes.”
- A mother of two children with six months in treatment answered, “I have learned to be able to deal with my children’s anger and resentment by allowing them to express their feelings and letting them know their feelings are valid and help them work through the feelings. Also I learned that my children need counseling to deal with the anger.”

The parents were able to look at parenting issues and apply the 12-Step process. The process helped them to look at their own behavior and see what they need to change. It helped most of the parents to recognize that their children’s needs have to come first, and to acknowledge that reunification may not always be what is best for a child. The parents realize that they need to remain open-minded when making decisions about what is best for their children.

Conclusion

This approach to parenting education enables parents in recovery to focus more on their behavior as parents rather than their children’s behavior. The class encourages parents to feel good about being a parent again after a history of alcohol and drug problems. When the parent class is in step with the parents’ recovery process, it gives them a consistent message that can be used throughout their new life. Parents who completed the class came away with some real life strategies to use. Finally, the information they received in the class was helpful not only with their children, but with their grandchildren and any other children with whom they came into contact.

Karen L. Cox, CADC
Owner, Positive Outlook Consultant Services

REFERENCE


UPCOMING CONFERENCE

Healing Havens for Families Affected by Substance Abuse

This national conference will bring together community members, service providers, administrators and policy makers to share information on developing and implementing shared family care and other innovative strategies that assist families affected by alcohol and other drugs to obtain the skills and resources they need for independent sober living. Cost: $125.

DATE: August 3-4, 2000
LOCATION: Berkeley, CA
SPONSORING AGENCY: National Abandoned Infants Assistance Resource Center
CONTACT: Margot Broaddus, AIA Resource Center, 1950 Addison St., Suite 104, Berkeley, CA 94704-1182. (510) 643-7018; Fax (510) 643-7019; margotb@uclink4.berkeley.edu; http://socrates.berkeley.edu/~aiarc.
FOCUS, a project of the San Joaquin County Office of Substance Abuse in Stockton, CA, was developed in 1989 in collaboration with a number of community service agencies to provide intensive day treatment services for high-risk women and children. A range of support, counseling, educational and therapeutic services at one site create an environment in which mothers and children can learn and practice new skills. Successful FOCUS clients learn to maintain drug and alcohol free lifestyles, provide safe and nurturing homes for themselves and their children, and develop healthy interpersonal relationships.

FOCUS serves over 100 families each year. The program is located in a redevelopment area of Stockton in a former motel facility, remodeled to suit the needs of the treatment program. Large childcare rooms that accommodate 60 children, eight large group rooms, a kitchen, dining rooms and staff offices surround a large courtyard that also serves as the children’s play area.

In over ten years of service provision, FOCUS has explored different program designs to maximize client success. Some of the program’s most valuable program components were not priorities in the original program design. These include: special services for women with histories of abuse and post-traumatic stress symptoms, intensive parent education and training, an extremely close collaboration with Child Protective Services (CPS), and a transitional housing program.

FOCUS ADAPTS PROGRAM TO MAXIMIZE CLIENT SUCCESS

FoCUS ADAPTS PROGRAM TO MAXIMIZE CLIENT SUCCESS

Excellence in Action

While the program demonstrates solid success with many of the families it serves (over 50% are successful in treatment), data from the FOCUS evaluation showed that women with certain risk factors were less likely to be successful in treatment. The two most critical risk factors were inter-related: 1) co-occurring mental health and substance abuse disorders, and 2) past or present abuse (domestic violence, child abuse, child sexual abuse, rape, etc.).

Upon further study, FOCUS found that these issues were more common than initially realized. In FY98, 55% of program participants reported having co-occurring substance abuse and mental health disorders. The most common mental health disorder reported by program clients was depression (43%), followed by anxiety (8.5%) and post-traumatic stress disorder (8.5%). Program data also showed that 95% of program participants had been physically or sexually abused and 35% were living in current abusive situations.

Program staff found that many mental health disorders (especially anxiety and depression) in women with abuse histories appeared to be symptoms of post-traumatic stress. Abuse has an enormous impact on the emotional and mental health of victims. The results may be long lasting and severe. Guilt, shame, self-blame, depression, suicidal feelings and dissociation resulting from trauma can be overwhelming to women attempting to recover from substance abuse (Najavits, Weiss and Liese, 1995). The National Institute of Mental Health defines Post-traumatic Stress Disorder (PTSD) as “a condition that may occur after exposure to a terrifying event in which grave physical harm occurred or was threatened. Traumatic events that can trigger PTSD include . . . personal assaults such as rape, physical and sexual abuse” (NIH, 1999). Research also shows that special services are needed for women with abuse histories. “Without treatment specific to trauma, victims of abuse experience more difficulty in substance abuse

Continued on page 16...
treatment and are more vulnerable to relapse” (Bollerud, 1990).

As a result of these findings, FOCUS and the Office of Substance Abuse increased their efforts to improve services for women, attempting to recover from the multiple issues of mental health, substance abuse disorders and abuse/violence, and their children. Strategies involved:
- educating staff about interpersonal abuse issues,
- providing individual and group therapy on abuse/trauma,
- providing anger management skills training, and
- including abuse issues in parent education and counseling.

**Intensive Parent Education and Training**

Staff also found that mothers’ dual disorders often severely impacted their children’s emotional, educational and developmental progress. Understanding that the life experiences of mothers have a profound affect on their parenting skills and abilities, FOCUS greatly increased the type and number of parenting services offered at the program.

Parent education classes are provided in three phases of two-months each. Twice weekly Interactive Parenting sessions are held in the child care rooms enabling mothers to practice new skills with their children with the guidance and support of staff. Mothers without custody of their children attend separate classes to deal with separation, grief and loss issues. All parenting services are tailored to specifically meet the needs of women in recovery from substance abuse and include detailed information on the parenting role, definitions of child neglect and abuse, information on child sexual abuse and family reunification issues.

**Collaboration with CPS**

FOCUS is a collaboration of ten different agencies that provide services at one site, but FOCUS has an especially close relationship with the staff of Child Protective Services. As a result, CPS allows the program to have significant input into reunification planning. Multi-disciplinary team meetings are held monthly with CPS, program staff and individual clients to report progress and to implement reunification timetables.

Additionally, CPS makes arrangements for children in foster care to attend the FOCUS program four days a week to spend time with their mothers. This allows the mother and child to bond, as well as allowing the mother to begin understanding her child’s needs. The program offers an array of services for children ages 0 to 5, including therapeutic child care, developmental assessments, immunization tracking, height and weight measurement, health checks and recreational activities.

**Transitional Housing Program**

FOCUS clients who need extra support have the option of living in a transitional housing facility operated by the San Joaquin County Office of Substance Abuse. The facility, Hermanas, provides clean and sober housing for women and children. The facility is staffed 24 hours a day, seven days a week and houses 45 families. Clients pay reduced rent for a studio or one-bedroom apartment. The facility is funded through Supportive Housing funds.

**Allies: Women, Co-occurring Disorders & Violence Study**

FOCUS clients also benefit from the Allies project. In 1999, FOCUS became a study site for a SAMHSA Women, Co-occurring Disorders and Violence Study grant. Under this grant program, the Office of Substance Abuse developed the Allies project, a collaboration with San Joaquin County Mental Health Services, San Joaquin County Children’s Mental Health, Valley Community Counseling and the Women’s Center of San Joaquin County. Allies has increased the ability of FOCUS to improve services in the following four ways.

**STAFF TRAINING**

Allies provides FOCUS staff with training on domestic violence; the correlation between abuse, mental disorders and substance abuse; and integrated relapse prevention. Training topics include dual diagnosis and PTSD, psychotropic medication and illegal drugs, and group therapy models for addressing trauma symptoms in substance abuse treatment programs.

Continued on page 24 . . .
This article explores the extent to which gender and related factors affect substance abuse treatment for women involved in the criminal system. To illustrate these issues, we draw upon the example of the Crossroads program, operated by the Center for Community Alternatives in New York, NY.

The Need for Gender Specific Treatment

There is considerable evidence of the link between maternal substance abuse and child abuse and neglect. In 1994, 77 percent of the 50,000 reports of child abuse and neglect filed in New York City involved substance abuse. An estimated 7,000 (77%) New York City children in foster care had biological parents who were substance abusers (CASA, 1996). The chemical dependency of women has had a significant impact on the criminal court as well. Women have been the fastest growing population in the criminal justice system. In 1986, there were 410,300 women under correctional supervision in the U.S.; by 1996 the number doubled to 859,400 (U.S. Department of Justice, 1999). Most women in the criminal justice system, regardless of offense, have substance abuse problems (Wellisch, Prendergast, and Anglian, 1994). Despite the effect of drug abuse on women and their families, women’s treatment needs tend to be overlooked and/or inadequately understood.

Research has shown that women differ significantly from men in terms of their pathways into crime and drug addiction (Daly, 1994) as well as their social and psychological characteristics (Wellisch et al., 1994; Wald, 1995). Symptoms of women’s addiction are typically “inner directed” appearing as anxiety, shame and depression, whereas male manifestations of addiction are more visible and external — drunk driving, fighting and assault (CASA, 1996).

The evidence with respect to the role that genetics plays in addiction is less clear for women than for men (Svikis, Velez, and Pickens, 1994). Women do, however, report more family history of drinking than do men (Finkelstein, Kennedy, Thomas, and Kearns, 1997). Research on neurotransmitters such as dopamine and serotonin have largely been conducted on animals and have not distinguished effects by gender (Finkelstein et al., 1997; Wilcox, Gonzales, and Erickson, 1994). More research has been done on gender-specific physiological consequences of drug use. The phenomenon known as “telescoping” suggests that women experience more severe consequences of drug use over shorter periods of time than do men (Finkelstein et al., 1997; CASA, 1996; Blume, 1990; Nesper, 1990; Reed, 1987). Women’s blood alcohol levels are higher than men’s of the same weight for similar levels of consumption due to differences in gastric metabolism, differences in body fat and body water levels (CSAT, 1994; Deal and Gavaler, 1994). Adverse health consequences for women include increased risk for liver disease, sexual dysfunction, menstrual and pelvic problems, heart disease and breast cancer (Finkelstein et al., 1997; CASA, 1996). Of special concern is the growing incidence of HIV among women. Women face multiple risk factors for HIV, most of which relate to drug use (e.g., their own or sex partner’s drug use, and their work as prostitutes in order to obtain drugs).

There are also unique social contexts to women’s addiction that are in large part associated with relationships with male partners and the greater social stigma attached to women’s use of drugs. Women often begin their drug use as part of a common activity with boyfriends; female addicts are more likely than male addicts to have a partner who uses illegal drugs (Lex, 1995). Women also use drugs as a form of comfort or numbing at the demise of a relationship (Amaro, 1995). Violent and abusive relationships are strong contributors to female substance abuse. Women’s roles as caretakers and nurturers may cause them to ignore or deny their drug abuse especially because they fear the loss of their children. Family reliance on the woman as caretaker often leads family members to deny or minimize the problem as well. Men’s drug and alcohol use is more socially tolerated and sometimes condoned as acceptable “machismo” behavior whereas drinking and drugging on the part of women engender greater social disapproval and are considered antithetical to traditional female roles of mother and wife.

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This social stigma also affects the ways professionals treat female addicts reflected by a reluctance to identify substance abuse problems in women or more punitive and negative attitudes toward female patients/clients (Chasnoff, 1989; Beckman, 1994; Finkelstein et al., 1997).

Treatment Issues

These contextual issues contribute to low self-esteem, poor coping skills, and mental health problems, notably depression, post traumatic stress disorder, eating disorders, anxiety and increased risk of suicide. Additionally, whereas chemical dependency knows no class or race boundaries, drug-addicted women who are involved in the court system most often come from poor and/or minority communities and experience myriad socioeconomic problems (Mitchell, 1993). These include lack of job skills and/or employment experience, limited access to transportation, lack of child care and homelessness. Therefore effective treatment for women must be holistic, addressing not just drug use, but underlying problems that contribute to drug use and relapse.

Services provided to women addicts must be set in a context that empowers them, improves coping skills, and helps them to develop functional support networks and greater life stability (Falkin, Wellisch, Prendergast, Kilian, Hawke, Natarajan, Kowaleswks, and Owen, 1994). Effective programming for women builds on their strengths, i.e., a competency-based approach (Nelson-Zlupko, Kauffman, and Morrison, 1995), rather than the more traditional deficit model. Additionally, it is important that program staff “can develop authentic, caring and trusting” relationships with clients (Finkelstein et al., 1997).

Treatment for women must recognize that women are not a monolithic genetic entity, but rather a diverse population with experiences and coping skills influenced as much by race, ethnicity and class as by gender (Banyard and Graham-Bermann, 1993).

There is also growing agreement that women-only programs can best meet the needs of women who abuse drugs and alcohol (Morash and Bynum, 1995; Falkin et al., 1994; CASA, 1996). Treatment issues that are most important to women’s abuse of drugs, such as domestic violence and sexual assault, are among the most uncomfortable to disclose in a coeducational group. Therefore, if the program is not for women only, it should offer extensive gender-specific treatment sessions. Peer support is also effective for women by providing supportive networks and role models for success. Similarly, case management is an especially effective service delivery strategy for women enmeshed in unstable, chaotic and fragile lives and who are often involved in multiple systems including family court, social services, child welfare, public housing, their children’s school systems and the criminal justice system.

A Treatment Model for Women: The Crossroads Program

Crossroads is a substance abuse day treatment program for women offenders operated by the Center for Community Alternatives (CCA) to serve as an alternative to incarceration in New York City. Crossroads delivers a range of services intended to address women’s treatment needs in a comprehensive, holistic manner, while ensuring accountability to the courts and criminal justice system. Although the program relies heavily on a group model, individual case planning remains a critical program component. Case management and court advocacy assist clients in negotiating fragmented human services, child welfare systems and Family Court to secure housing and entitlements and to address domestic violence and child custody issues.

Crossroads provides the following services:

- group and individual substance abuse counseling;
- survivors groups (related to sexual abuse and domestic violence);
- HIV/AIDS services;
- acupuncture to aid in detoxification and relapse prevention;
- urinalysis;
- family groups;
- parenting groups;
- job readiness, vocational counseling, employment placement;
- life skills training;
- mental health counseling and medication (when warranted);
- family and criminal court advocacy services; and
- case management including referral to housing, health, prenatal and child care.

PARTICIPANT AND STAFF CHARACTERISTICS

Crossroads serves approximately 75 women a year. The socio-demographic characteristics of program participants are indicative of a population that has significant histories of substance abuse, physical and sexual abuse, and court involvement. As Crossroads is designed as an alternative-to-incarceration, all
women who participate in the program are facing criminal charges at the time of their referral. The typical program participant is charged with a felony and has a prior criminal history. Roughly 55 percent of program participants are African American, 40 percent Latina and 5 percent Caucasian. About 80 percent of participants have one or more children, and while half report loss of custody, almost all want to maintain or regain custody of their children. About one-quarter of program participants are HIV-infected and about 85 percent report past sexual and physical victimization.

Program staff have various professional degrees, but the majority are master’s or bachelor level social workers and credentialed substance abuse counselors. Court advocates typically have law degrees or master’s degrees in criminal justice. All counseling staff are trained in ear point acupuncture and the program also uses the services of a licensed acupuncturist. Other program consultants include a psychiatrist and a nurse practitioner. Most staff are women, but there are usually one or two men on staff. Staff are racially and ethnically diverse; approximately two-thirds of the staff are from communities of color, and several are Spanish speaking.

**PROGRAM OPERATION**

Crossroads employs a system of program phases that guides the nature of program contacts and requirements. Women remain in the program for six-to-twelve months, depending upon treatment needs and/or court mandate. The three phases of Crossroads treatment are: (1) Assessment and Stabilization; (2) Decision-Making; and (3) Community Schedule. As the client proceeds through Phases I and II, controls are lessened contingent upon demonstrated progress. Phase III focuses on community transition, employment or educational or vocational training, and the development of a community-based network of comprehensive aftercare.

A special program protocol for pregnant women makes prenatal care mandatory and case managers accompany pregnant clients to their initial visits with their medical provider and monitor subsequent visits. HIV prevention education and HIV/AIDS support services are high service priorities because of the high incidence of HIV infection among the Crossroads population and the characteristics that place virtually all program clients at high risk. HIV education groups are offered to all clients, and support groups and services are available to those clients who have already tested HIV positive.

Through recreational activities, such as picnics, movies, museums and plays, clients learn how to enjoy their free time and how to socialize with other sober individuals. Family activities are also important, particularly those that include the clients’ children.

Criteria for successful completion or “graduation” include movement through the phases of the Crossroads program, compliance with program rules, and maintenance of sobriety. Clients who meet these criteria are eligible to graduate after eight to twelve months of program participation. Actions that can lead to program termination, such as rearrest, absconding from the program, continued drug use combined with refusal to comply with treatment recommendations, are evaluated in the context of the client’s overall functioning. With judicial consent, Crossroads employs a range of methods and “graduated sanctions” before recommending that the client be terminated.

**OUTCOMES AND BENEFITS**

The benefits of Crossroads are best illustrated through Mary’s story. Mary, a 41-year old single mother of two, was referred to Crossroads in June 1998, after being charged with a felony-level drug crime. Mary’s substance abuse history began at age 13; upon her entry into Crossroads, she was snorting heroin, drinking alcohol and smoking crack daily. A relative had adopted Mary’s 14-year old daughter, and her 4-year old son was in foster care. Mary was consumed with guilt and shame, which exacerbated her drug abuse. She relapsed in the early phase of her treatment and was referred to a detox program after which she returned to Crossroads.

This proved to be the turning point in Mary’s recovery and she became a very positive role model for her peers. After completing a 16-week vocational training program, Mary became employed and was reunited with her son, with whom she presently lives.

**Conclusion**

Mary’s story is similar to many women who enter Crossroads. The savings are in human and financial terms. Last year Crossroads saved 71 years of incarceration resulting in a savings of $2 million. Investing in drug treatment for women offenders can save their lives and avoid the destructive consequences of imprisonment.

**Marsha Weissman, Executive Director**
**Kathleen O’Boyle, Deputy Director**
**Center for Community Alternatives, New York, NY**

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Continued from page 19 . . .

REFERENCES


The spring issue will focus on HIV testing of newborns. Individuals are encouraged to submit abstracts for articles that discuss: (1) state laws regarding HIV testing of newborns; (2) hospital policies and procedures regarding reporting of test results; (3) hospital staff training on reporting test results; (4) effective services or programs for families with HIV positive newborns; (5) use of rapid HIV testing and post-exposure prophylaxis for newborns; (6) HIV testing and counseling for pregnant women; and (7) ethics of testing women by proxy without their consent.

As always, an AIA program will also be featured in each issue. Interested staff from any AIA program is encouraged to submit an abstract. The article should discuss how the program uses harm reduction strategies to serve its clients and how this is reflected in agency or program policies (winter issue), or how the program works with families with HIV positive newborns (spring issue).

To be considered for publication, please send/fax/email a brief (150-200 words) abstract of your proposed article to the AIA Resource Center at the address below. Abstracts for the winter issue on harm reduction are due no later than Friday, July 14, 2000. Abstracts for the spring issue on HIV testing are due no later than Friday, September 8, 2000. Authors of accepted articles will be notified within a few weeks of each deadline.

CALL FOR ARTICLES

The AIA Resource Center is soliciting articles for the winter 2000/2001 and spring 2001 issues of The Source. The winter issue will focus on the use of harm reduction strategies with families affected by substance abuse and/or HIV. We are looking for articles that address any of the following: (1) harm reduction principles and the advantages and challenges of applying those principles in work with families; (2) strategies for incorporating harm reduction into direct services with families affected by substance abuse and/or HIV; (3) balancing harm reduction and child safety; or (4) developing harm reduction policies on the state, local or agency level.

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SEND ABSTRACTS AND DIRECT QUESTIONS TO:

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The Linkage Project became operational in 1990 in response to the growing number of drug-exposed infants born in the metropolitan area of Kansas City, Missouri. This project was designed to provide follow-up, tracking and interagency systems coordination to mothers, drug-exposed infants and their families in order to reduce the future risk of child abuse and neglect. Goals of the project were to: (1) enhance the quality and scope of services provided to drug-exposed infants and their families by prompting better interagency systems coordination, and (2) reduce the risk of child abuse and neglect of drug-exposed infants by utilizing all available means to advocate for the delivery of appropriate and adequate service intervention.

This article discusses the development and implementation of the Linkage Project, and the project’s impact on the identification of drug-exposed infants and increased awareness of perinatal substance abuse. Lessons learned from the Linkage Project can be instrumental in establishing similar projects in other communities.

* Division of Family Services/Health and Human Services Baby Doe funds, KC PACT (Kansas City Prevention, Assistance, Coping Skills and Teaching), Missouri Department of Health/Alcohol and Drug Abuse Division, TIES (Team for Infants Endangered by Substance Abuse), and COMBAT (Community Backed Anti-Drug Tax—special tax from Kansas City) provided monetary assistance at different points in time.

**Project History**

The Metropolitan Task Force on Drug-Exposed Infants (Task Force) was formed in 1989 in Kansas City, Missouri. The Task Force, consisting of physicians, health care providers, social workers, child welfare staff, court representatives, educators, and community activists, studied problems related to perinatal substance abuse, e.g., medical non-compliance of pregnant users, child protection standards, and perinatal and postnatal case management. The Task Force found that while hospital social workers noted increasing numbers of drug exposed or affected newborns, the Division of Family Services often could not offer services due to statutory restrictions. Thus many infants were released to parents, who continued to use illicit drugs or abuse alcohol, with no plan in place to monitor the welfare of these fragile babies.

The Linkage Project evolved as a point of entry to unite community agencies in the formulation of a safety net for this population. The project began with grants from several different public and private agencies*. In 1997, the project was absorbed by the budget of Jackson County Family Court. In-kind services in the form of office space, telephone services and clerical support were provided by the Social Work Departments of Children’s Mercy Hospital (CMH) and Truman Medical Center-West (TMC-W). The directors of the departments were instrumental in the initial program design and strong supporters of the project. A Project Coordinator was hired in 1990 as an employee of Jackson County Family Court (JCFC).

**Project Components**

The primary components of the project include: the Coordinator, hospital assessment and referral, linkage to community services, and community outreach.

**Responsibilities of the Linkage Coordinator**

As the hub of the project, the Linkage Coordinator has the following general responsibilities:

- Meets with medical social workers regarding discharge planning of drug exposed infants.
- Coordinates the linkage of services between agencies and programs providing services to the families.
- Coordinates conferences to assess identified concerns and gaps in services for high-risk families.
- Monitors medical treatment and compliance and institutes follow-up as necessary.

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- Identifies families needing other community services and recommends the disbursement of available funds.
- Makes in-home visits and telephone contacts to referred families.
- Developed a statistical tracking system for drug exposed infants.
- Provides education to the community and state regarding this population.

HOSPITAL ASSESSMENT AND REFERRAL

Referrals to the Coordinator are primarily made by the medical social workers, nurses or doctors at eight Jackson County hospitals when a mother’s self-admission, prenatal toxicology or mother/infant delivery toxicology identify an illegal substance or alcohol. Each referring hospital developed policies regarding the referral process. However, a positive toxicology screen at delivery always involves a referral to the Coordinator. A request for a Newborn Crisis Assessment (conducted by a special team of social workers on behalf of Division of Family Services) is either dictated by hospital policy or made in consultation with the Coordinator. This decision is based on several factors including: prenatal care or lack thereof, positive prenatal screens, previous drug exposed infants, family support, past, present or future treatment, and/or a review of other social issues. However, a hospital routinely requests a Newborn Crisis Assessment on cases when the mother or baby tests positive at delivery.

Shortly after the Project was implemented, new legislation, which focuses on health care protocols for pregnant women, was enacted. Chapter 191, RSMo, commonly known as Senate Bill 190, requires health care providers who serve pregnant women to be responsible for:
- Assessing prenatal clients for substance abuse and associated risk factors;
- Counseling all prenatal clients regarding the risk to themselves and the fetus;
- Retaining a signed statement from the client in her permanent medical record verifying she has received this counseling and education; and
- Offering treatment and/or service coordination referral for pregnant women identified as at risk.

In response to this legislation, the Linkage Coordinator worked with the hospitals to develop assessment and referral protocols, and she made presentations to staff (doctors, nurses, medical students, and medical social workers) demonstrating how to interview and assess a patient actively using illicit drugs or at risk for using. Many times, the presentations also included medical information presented by an obstetrician or neonatologist who had worked with this population for many years.

SERVICE LINKAGE AND COLLABORATION

The Linkage Coordinator also provides hospitals and patients with information about treatment options and community resources. These include the Comprehensive Substance Abuse Treatment and Rehabilitation (CSTAR) programs that offer gender specific treatment through the Missouri Department of Mental Health, Division of Alcohol and Drug Abuse. CSTAR programs provide in- and out-patient treatment for women, as well as childcare, therapeutic interventions/activities for children, transportation, health care, psychiatric evaluation referrals, housing and employment/training referrals. The Linkage Coordinator developed partnerships with the two local CSTAR programs (North Star Recovery Services and Renaissance West) regarding referral for treatment and exchange of information. Referrals are also made to other local outpatient providers.

Additionally, the Coordinator serves as a liaison between the families and the Division of Family Services (DFS). A legal basis for the exchange of information between the DFS and the Coordinator was grounded in RSMo 210.110-210.165. This statute provides for “free exchange of information” to individuals or organizations involved with drug exposed children who are noted in a child abuse and/or neglect investigation request. Written parental consent is required for cases not under investigation, and the Coordinator has to receive consent prior to offering or engaging in additional fact finding.

The following scenario is an example of community collaboration:

Ms. H gave birth to her second child, a male infant exposed to marijuana. She had received no prenatal care. Hospital staff made a referral to the Linkage Coordinator (LC). The Public Health nurse made a visit shortly thereafter and concerns were noted (e.g., infant was developing thrush and the mother’s interest in the baby had changed). This information was conveyed to the LC. The LC contacted the Bureau of Special Health Care Needs (BSHCN) worker who was preparing to make a
home visit and develop a case plan. The LC made another home visit at the request of the BSHCN worker, and the infant’s physician was contacted. The mother refused substance abuse treatment. The infant was hospitalized and the Division of Family Services was contacted on the Missouri side as well as Social and Rehabilitation Services (SRS) in Kansas where the infant was voluntarily placed with the paternal grandmother.

The ability to share information was critical for accurate assessment. The cooperative efforts of the seven service providers created a safety net that did not allow the family to fall through the cracks or become lost in a bureaucratic maze. Thus, the linkage of services and interagency collaboration reduced the risk of abuse and neglect for this child.

Finally, in 1998, the Family Court Division of Jackson County established a Family and Juvenile Drug Court with the intention of expeditiously intensifying the treatment and legal process for families affected by substance abuse. The addition of this court further improves service coordination for these families, and empowers them to make positive lifestyle changes.

COMMUNITY OUTREACH

Community outreach continues to be another important component of the Linkage Project. Media exposure (through radio, television, and local medical journal and newspaper articles) regarding the medical, social and legal impact of substance abuse contributed to the expansion and maintenance of the “safety net” for drug exposed infants. An informational flyer regarding services in the community was distributed to over 30,000 households in the metropolitan area over two different time periods. This effort was conceived through the Continuum of Care Committee, which was a group of treatment, intervention and prevention providers who developed strategies designed to help women more successfully access services. This outreach coincided with Substance Abuse Awareness month in the community, and the target population included non-users who might know an active user.

Lessons Learned

The project’s effectiveness can be measured in several ways: the identification of illicit drug use during pregnancy, appropriate intervention post-delivery, and community collaboration.

Although no formal evaluation of the program has been conducted, anecdotal evidence suggests a heightened awareness of perinatal substance abuse and an increase in drug screening pre- and post-natally. The increase in the number of identified drug-exposed infants between 1994 and 1999 (see chart below) may be due, at least in part, to better screening.

<table>
<thead>
<tr>
<th>Year</th>
<th>Number</th>
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<tbody>
<tr>
<td>1994</td>
<td>231</td>
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<tr>
<td>1995</td>
<td>316</td>
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<td>414</td>
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<td>1997</td>
<td>375</td>
</tr>
<tr>
<td>1998</td>
<td>373</td>
</tr>
<tr>
<td>1999</td>
<td>312</td>
</tr>
</tbody>
</table>

The gradual decline since the peak in 1996 may be attributable to early intervention with addicted pregnant women, and to pregnant women crossing the state line to deliver in Kansas where there is no routine drug testing. Additionally, the increase in Newborn Crisis Assessments requested between 1994 (114) and 1999 (243) may directly reflect the increase in drug-exposed infants as well as improved screening and referral procedures.

Further, subsequent drug exposed infants, although born at different hospitals, can now easily be identified through the statistical tracking of the Project. Sharing historical and current information with the Division of Family Services via the Newborn Crisis Team provides an opportunity for more in depth assessments and ultimately better protection for infants.

Kansas City was truly a community committed to meeting the challenges of substance abuse. Hospitals, physicians, judges, treatment specialists, child welfare workers, guardian ad litem, family therapists, medical social workers, and others joined together and recognized that setting aside differences and active listening were important resources they could offer. The professionals also realized that their creative use of community resources for families struggling to overcome the ravages of substance abuse was of the utmost importance. Without this expectation of communication and commitment, families may not receive the best these professionals have to offer.

The Linkage Project helped Kansas City to prioritize and change the way many institutions interact with one another. Credit must be given to all that participated in the process, as it was not always easy. Addressing territorial issues, educating multidisciplinary staff from different agencies about the intricate field of substance abuse, and

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developing new ways of communicating all contributed to the process of change. Specific practices and policies in this community addressed the issues of chemical dependency and created heightened awareness. Community wide accountability improved the chances of maintaining the longevity of the Project.

Conclusion

Balancing the needs of the child (protection) and the needs of the family (strengthening) can be difficult when substance abuse is involved. This is exacerbated by the fact that the ebb and flow of recovery and relapse does not always coincide with the needs of the child, the expectation of service providers and the legal system.

Prevention can begin at any point. If a community is unable to “prevent” substance abuse during a pregnancy, then prevention picks up at delivery. The Linkage Project offered infants in Kansas City a “safety net.” Any community, large or small, can benefit from a similar project. The journey begins with the first step.

Penny E. Howell, MSW, LMSW, Kansas City, MO

INTENSIVE CASE MANAGEMENT

Allies provides intensive case management for high-risk women, including those in the FOCUS program. Case managers work with a caseload of 15 families to empower women to recognize their need for services and to take control of their lives. They serve as a single contact point for women with the social services and health care systems, support women in transition between services, assess the needs of women and their children, and make appropriate referrals.

GROUP TREATMENT

Allies is developing a counseling group at FOCUS for women with co-occurring substance abuse and mental health disorders with histories of interpersonal abuse. The group follows Seeking Safety, a group model based on research that links personal histories of traumatic incidents to the abuse of drugs and alcohol and resulting mental disorders. Seeking Safety groups use cognitive-behavioral therapy techniques to teach clients to establish safety in their lives and to practice self-care and self-soothing techniques. Maintaining sobriety and learning triggers to relapse are emphasized.

THERAPY FOR WOMEN AND CHILDREN

Allies provides therapy for women and children on issues resulting from abuse, such as post-traumatic stress disorder, anxiety and depression, eating disorders, parenting issues, and grief and loss.

Conclusion

Over the past ten years, the FOCUS program has developed new components, attempting to continually respond to the needs of the families it serves. Although FOCUS was originally conceptualized as a substance abuse program, it soon became clear that the families involved needed more than just substance abuse treatment—that only by including a range of personal and family services could the program, and its clients, succeed.

As FOCUS continues to serve families in the community, staff will also continue to search for opportunities to update the services and maximize client success.

Frances Hutchins
San Joaquin County Office of Substance Abuse

REFERENCES


Guide to Possibility Land: Fifty-One Methods for Doing Brief, Respectful Therapy

This book offers humorous, compassionate techniques in approaching action-oriented therapy in a lively and accessible text. It empowers the reader with a huge selection of strategies and techniques. Cost: $11.70.


EMDR in the Treatment of Adults Abused as Children

This book shows therapists how to integrate EMDR (eye movement desensitization and reprocessing) into treatment so that adults who have been abused as children clear their trauma more rapidly and proceed to lead full, productive lives. The book also covers the primary treatment issues and symptomatology of these clients and offers a safe way for therapists to treat abuse survivors. Cost: $27.00.

L. Parnell, 1999. 222 pages. Available from W.W. Norton, 500 Fifth Avenue, New York, NY 10110. (800) 233-4830. Fax: (800) 458-6515. E-mail: npb@wwnorton.com.

Family Recovery and Substance Abuse: A Twelve-Step Guide for Treatment

This book offers clinicians a structured, research-based approach to working with family members of substance abusers. Emphasizing unilateral family therapy, this book offers therapists methods to improve the well-being of concerned significant others and to teach them how to restructure their relationship to the substance abuser in ways that may enhance the substance abuser’s motivation to change. Cost: $27.95.


Collaborative Therapy With Multi-Stressed Families: From Old Problems to New Futures

This book offers an alternative approach to working with multi-stressed families on a collaborative basis. It provides guidelines for conducting nonpathologizing assessments and strategies for engaging reluctant clients in treatment. Therapists learn concepts and strategies to help clients shift their relationship to the problems in their lives and develop communities of support; to successfully collaborate with other helping professionals; and to revision agency structures, procedures and paperwork. Cost: $35.00.


Life After Trauma:
A Workbook for Healing

This self-help supportive workbook, for those who have suffered a life trauma, is filled with comforting activities, relaxation techniques, and self-evaluation questionnaires that provide guidance and step-by-step resources for coping, self-understanding and self-care. Cost: $17.95.


Supporting the Kinship Triad

This five-day curriculum training book offers participants a clear and concise delivery model that is time limited, culturally sensitive, strengths based, and rooted in family preservation. Participants learn how assessment applies to kinship care, how to use specific interventions to support a kinship living arrangement, and how kinship care fits into the larger context of permanency planning for children. The curriculum includes a 3-ring binder, divided sections for each day’s session, and resource materials. Cost: $395.00.


Managing Anger

This workbook will help those in recovery programs to better understand and deal with their anger. Designed for use in counseling/therapy sessions or self-help programs, it provides an understanding of the roots of anger and styles of coping, and it addresses anger management problems, mental health issues, and healthy coping strategies. Cost: $11.95.

D.C. Daley, 1999, 21 pages. Available from Learning Publications, Inc., P.O. Box 1338, Dept. DC95, Holmes Beach, FL 34218-1338. (800) 222-1525, Ext. DC95; Fax (941) 778-6818; www.bhip.inf.net/-lpi.

Recipe For Recovery: Group Process for Women’s Addictions to Violence, Self Destruction, and Abuse

Useful to professionals working with women who suffer from substance abuse and lack of self-esteem, this workbook uses clinical techniques and exercises to assist in treating this population. The authors use the “Four-A’s”: awareness, acceptance, action and attitude adjustment as guides for treatment, and they suggest several group process activities to increase self-awareness about addiction and the use of violence. Issues of self-destruction and abuse are also discussed. Cost: $15.95.

M. Blomgren, 1999, 75 pages. Available from Learning Publications, Inc., P.O. Box 1338, Dept. DC95, Holmes Beach, FL 34218-1338. (800) 222-1525, Ext. DC95; Fax (941) 778-6818; www.bhip.inf.net/-lpi.

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Young Children and Foster Care: A Guide for Professionals

This book offers a multidisciplinary discussion of children in the child welfare system. It features basic information on child development, highlights important issues for children in the child welfare system, and presents expert advice on aspects of care that are often overlooked, e.g., foster parent training, developmental disabilities, child placement issues, advocacy, motor skills and spirituality. It also includes examples of innovative programs and creative models for prevention and intervention. Cost: 39.95.


The Social World of Children Learning to Talk

This book describes how parent-child interactions help babies learn to speak. It also charts the month-by-month growth in a child’s vocabulary, utterances, and use of grammatical structures; describes the ambient conversation and changing patterns of parent-child interaction; and includes an extensive appendix of children’s vocabulary from 19 to 36 months of age, as well as actual transcripts of children and parents speaking. Cost: $24.00.


Drug Abuse: Research Shows Treatment is Effective, but Benefits May Be Overstated

This report is a response to a request by the U.S. Congress to evaluate four areas of drug treatment effectiveness in the United States: (1) the level of support for drug abuse treatment; (2) the treatment approaches and settings most commonly used and what is known about faith-based treatment; (3) research issues affecting drug abuse treatment evaluations; and (4) research findings on the effectiveness of drug treatment overall as well as treatment specifically for heroin, cocaine and adolescent drug addiction. Cost: First copy is free. Additional copies are $2 each.


The Primary Recovery Plan: Practical Solutions for the Substance Abuse Client

This educational program contains a facilitator’s guide, reproducible client modules and client folders that help clients learn the basics of treatment and recovery; introduce the 12-step program; and define mood altering substances, abuse and dependency, and physical and psychological effects of drugs. The program explores substance abuse issues such as anger, depression, shame, grief and loss, family issues and relapse prevention. Cost: $395.00 (Complete package includes 1 facilitator’s guide, 258 pp; 1 module set with 14 reproducible modules; and 25 client folders).

Hazelden Experiential Learning Program, 1999. Available from Hazelden, 15251 Pleasant Valley Road, P.O. Box 176, Center City, MN 55012-0176. (800) 328-9000; Fax (651) 213-4590; www.hazelden.org.

Ethical Standards for Drug Abuse Counselors Workbook, Revised Edition

This workbook is designed to help drug abuse counselors who seek licensing or certification to meet the National Association of Alcoholism and Drug Abuse Counselors’ ethical standard guidelines for treating drug abusers. It addresses ethical standards and dilemmas and client welfare and relationships, and includes worksheets for analyzing ethical dilemmas and guidelines for reducing litigation for malpractice. Cost: $21.95.

N. Richardson & T. McEntee, 1999. 105 pages. Available from Learning Publications, Inc., P.O. Box 1338, Dept. DC95, Holmes Beach, FL 34218-1338. (800) 222-1525, Ext. DC95; Fax (941) 778-6818; www.bhp.info.net/~lpi.

Drug Abuse: Estella’s Story

This video gives social workers and counselors an honest portrayal of life as a drug addict. In a candid interview, Estella, a 33-year-old addict, describes her abusive past, her attempts to ease the pain with drugs, and the violent relationship she has with her children. The video targets young females with unstable environments and drug use activity. Estella effectively demonstrates how escaping an abusive past through drugs is not a viable solution. Cost: $149.95.


From Surviving to Thriving: A Therapist’s Guide to Stage II Recovery for Survivors of Childhood Abuse

This book provides information about obtaining and maintaining autonomy and quick recovery in the age of managed care. It combines both theory and practice and supports the therapeutic partnership with a step-by-step outline of the healing process. The author includes case studies, interviews, diagnostic criteria, and personal reflections from her clients. Cost: $24.95.

M. Bratton, MS, LPCC, MAC, 1999. 281 pages. Available from the Haworth Press Inc., 10 Alice St., Birmingham, NY 13904-1580. (800) HAWORTH; Fax (800) 895-0582; Email getinfo@haworthpressinc.com; www.haworthpressinc.com.

Foundations for Success: Strengthening Your Agency Attorney Office

This book gives agency attorneys advice on improving office management, strengthening agency relationships with other organizations, and providing better services to children and their families. The author covers how to establish caseload standards, develop practice standards, improve working relationships with caseworkers, implement the Adoption and Safe Families Act, get the most from your performance evaluations, and select and retain quality staff. Cost: $14.95.

M. Laver, 1999. 221 pages. Available from the American Bar Association, P.O. Box 10892, Chicago, IL 60610-0892. (800) 285-2221.

“I Never Told Anyone This Before”: Managing the Initial Disclosure of Sexual Abuse Re-Collections

This book helps the reader to work with clients who disclose memories of sexual abuse in an ethical, effective manner based on empirically tested guidelines. The author covers the therapeutic use of memories of sexual abuse, the false memory debate and how to
avoid legal risks, the function of memory in identity formation, and the facilitation of disclosures of traumatic history. Cost: $24.95.

J. A. Gasker, D.S.W., 1999. 172 pages. Available from the Haworth Press, Inc., 10 Alice St., Birmingham, NY 13904-1580. (800) HAWORTH; Fax (800) 895-0582; Email getinfo@haworthpressinc.com; www.haworthpressinc.com.

Family Group Decision Making: Communities Stopping Family Violence

This short booklet is a companion to the Widening the Circle video on Family Group Decision Making. Written in question and answer format, the booklet addresses what Family Group Decision Making is, how family conferences are organized, what happens at family conferences, and how to involve the community in this process. Cost: $ 6.50.


This book and tape integrate cognitive behavioral skills and education about the politics of abuse while maintaining the primary emphasis on respect for the abuser himself. The 32-session treatment model is broken down into five sections: foundations, brief interventions, self-management, relationship skills, and relapse prevention. The author includes specific skills-training exercises, handouts, and homework. Cost: $29.00.


Overcoming Addictions: Skills Training for People with Schizophrenia

This book helps therapists teach groups of individuals with schizophrenia how to avoid drugs and alcohol, recognize signs that they may be headed toward relapse, and build healthy habits and healthy pleasures into their daily routine. The authors include role-plays on everything from how to refuse drugs from a dealer to how to report symptoms and side effects to a doctor. They also include an extensive appendix of materials, tests and forms to help the therapist implement the program. Cost: $25.00.


Parenting One Day at a Time: Using the Tools of Recovery to Become Better Parents and Raise Better Kids

This book offers a practical approach to better parenting based upon the foundation of 12-Step recovery. Many facets of family relationships are covered, e.g., handling conflict, respecting the needs and feeling of others, behaving morally and responsibly, building trust and intimacy, and taking care of oneself.

A.J. Packer, 1996. 295 pages. Available from Hazelden, 15251 Pleasant Valley Road, P.O. Box 176, Center City, MN 55012-0176. (800) 328-9000; Fax (651) 213-4590; www.hazelden.org

Steps to Success: Helping Women with Alcohol and Drug Problems Move from Welfare to Work

This report profiles 20 alcohol and drug treatment programs in seven states that are models in meeting the needs of women in welfare-to-work programs. Cost: Free.


Integrating Alcohol and Drug Treatment into a Work-Oriented Welfare Program: Lessons from Oregon

This report reviews the importance and challenges of integrating alcohol and drug treatment into welfare-to-work programs, and uses lessons learned from Oregon’s experience doing this to provide insights about how states can address alcohol and drug problems as part of their effort to shift to a temporary, work-oriented assistance system. Cost: Free.


Blending Perspectives and Building Common Ground: A Report to Congress on Substance Abuse and Child Protection

Legislatively mandated through ASFA, this report describes the extent and scope of the problem of substance abuse in the child welfare population; the types of services provided to this population; the effectiveness of these services; and recommendations for legislative changes that might be needed to improve services coordination. Cost: Free.


Substance Abuse Treatment for Persons with Child Abuse and Neglect Issues

The 36th in a series of CSAT Treatment Improvement Protocols, this report offers guidance to substance abuse treatment counselors and other providers in identifying and treating adults with alcohol or drug addictions who are survivors of childhood abuse. Cost: Free.


Alcoholism & Drug Abuse Weekly

This 8-page weekly newsletter provides up-to-date information on policies, law, practice, funding, and events related to substance abuse. Cost: $499 for annual subscription.

Available from Manisses Communications Group, Inc., 208 Governor St., Providence, RI 02906. (401) 831-6020 or (800) 333-7771; Fax (401) 861-6370.
2000 Family Group Decision Making Roundtable: Advancing Innovations

Building on the past three years, this roundtable provides the opportunity for a diverse group of participants to exchange information about approaches, partnerships, policies and efficacy related to family group decision making. Cost: $365 (AHA member); $395 (non-member).

DATE: June 1-3, 2000
LOCATION: Madison, WI
SPONSORING AGENCY: American Humane Association, The National Center on Family Group Decision Making
CONTACT: Mickey Shumaker, AHA, 63 Inverness Drive East, Englewood, CO 80112-5117. (303) 925-9416; Fax (303) 792-5333. mickey@americanhumane.org.

Making Choices as a Diverse Society: Taking Responsibility for a Promising Future

Workshops on diversity and cultural competence will address specific topics such as: diversity training, conflict resolution, organizational development, sexual harassment prevention, cultural competence in health care, and cross-cultural communication. Cost: $330 – 830 (student discounts available).

DATE: June 1-4, 2000
LOCATION: Washington DC
SPONSORING AGENCY: National Multi-Cultural Institute
CONTACT: National Multi-Cultural Institute, 3000 Connecticut Avenue, NW, Suite 438, Washington DC 20008. (202) 483-0700; Fax (202) 483-5233; nmci@nmci.org; www.nmci.org.

Making Connections with Infants and Toddlers

This 4th annual conference for infant and toddler specialists will present strategies and techniques for enhancing the ability of parents and caregivers to foster the healthy development of children. A preconference on June 1 will focus on early brain development. Cost: $198 ($125 for one day; $100 for pre-conference).

DATE: June 2-3, 2000
LOCATION: Fort Lauderdale, FL
SPONSORING AGENCY: NOVA Southeastern University
CONTACT: Anthony Corbett, NOVA Southeastern University, Family Center, 3301 College Avenue, Fort Lauderdale, FL 33314-7796. (800) 836-8326; anthonye@nsu.nova.edu.

Developing Local Systems of Care for Children and Adolescents with Emotional Disturbances and their Families: Improving Policy and Practice

This conference contains four separate half-day seminars on a wide range of topics critical for developing and operating comprehensive, coordinated, community-based, family focused, culturally competent systems of care for children and adolescents with or at risk for emotional disturbances and their families. It will also address how to create clinical interventions, with a special focus on policy and practice interactions. Cost: $695.

DATE: June 9-13, 2000
LOCATION: New Orleans, LA
SPONSORING AGENCY: Training Institutes, National Technical Assistance Center for Children's Mental Health
CONTACT: National Technical Assistance Center for Children's Mental Health, Georgetown University Child Development Center, 3307 M Street, NW, Suite 401, Washington DC 20007-3935. (202) 687-5000; Fax (202) 687-1954.

14th National Child Protective Services Risk Assessment Roundtable

The theme of this year’s roundtable is continuity in terms of how issues presented by children and their families are handled, and how issues between researchers, policy makers and practitioners are handled. Cost: To be determined.

DATE: July 12-14, 2000
LOCATION: San Francisco, CA
SPONSORING AGENCY: American Humane Association and the American Public Human Services Association
CONTACT: Mickey Shumaker, AHA, 63 Inverness Dr. East, Englewood, CO 80112-5117; (303) 925-9416 or (303) 792-9900; Fax (303) 792-5333; mickey@americanhumane.org; www.americanhumane.org.

Colleagues for Kids Connecting to Make a Difference

This 8th annual colloquium will provide advanced interdisciplinary education in the field of child maltreatment through skill-building seminars that combine research and practice. Topics will include prevention, assessment, intervention and treatment with victims, perpetrators and families affected by physical, sexual and psychological abuse and neglect. Cost: $385 (APSAC member); $450 (nonmember); student rates available.

DATE: July 12-15, 2000
LOCATION: Chicago, IL
SPONSORING AGENCY: American Professional Society on the Abuse of Children
CONTACT: T-REX, 313 South 34th St., Geneva, IL 60134. (877) 309-1565 or (630) 262-1599; Fax (630) 262-1520; www.apsac.org.
Schools as Family and Community Resources

This conference brings together hundreds of participants from schools, child care establishments, community-based organizations, businesses, and other child and family serving agencies to address the challenges and successes of providing a range of school-based and school-linked services to children and their families. Cost: To be determined.

DATE: July 18-21, 2000
LOCATION: New Haven, CT
SPONSORING AGENCY: School of the 21st Century, Yale University
CONTACT: Jennifer Heath, School of the 21st Century, Yale University, 310 Prospect St., New Haven, CT 06511-2187. (203) 432-9943; Fax (203) 432-9945; jennifer.heath@yale.edu.

NIMH Conference on the Role of Families in Preventing and Adapting to HIV/AIDS

This conference will present research findings on family process and HIV disease. The focus is on family processes associated with the epidemiology of AIDS; coping strategies mobilized by families affected by HIV and AIDS, and issues associated with multiple losses, death, bereavement, child custody, and permanency planning. Secondary objectives of the conference include attracting more researchers on the subject, and generating new ideas and collaborations. Cost: To be determined.

DATE: July 26-28, 2000
LOCATION: Chicago, IL
SPONSORING AGENCY: National Institute on Mental Health
CONTACT: Mrs. Robin Tolliver, B I. Seaman & Associates, Inc., 4221 Forbes Blvd., Suite 245 Lanham, MD 20706. (301) 577-0244; Fax (301) 577-5261; robins@bleasoon.com.

Healthy Families America: Sharing Our Strengths

This conference provides an opportunity for individuals who work with children and families to network, share and learn the latest advances in child abuse prevention and home visiting. Cost: $200 (before July 14, 2000); $225 (after July 14, 2000)

DATE: September 9-12, 2000
LOCATION: Atlanta, GA
SPONSORING AGENCY: Prevent Child Abuse America
CONTACT: Kenda Eisnera, Prevent Child Abuse America, 200 S. Michigan Avenue, 17th Floor, Chicago, IL, 60604. (312) 663-3520, ext. 141.


This conference will feature practice, policy, training and partnership innovations that focus on social work and community based systems of protection and support, as well as collaboration with other helping professions. Cost: To be determined.

DATE: September 16-19, 2000
LOCATION: Snowbird, UT
SPONSORING AGENCY: Family Preservation Institute of New Mexico, University of Utah Graduate School of Social Work, and National Association of Public Child Welfare Administrators
CONTACT: Dr. Norma Harris, Graduate School of Social Work, 395 S. 1500 E., Rome, 111, Salt Lake City, UT 84112; (801) 581-3822; nharris@socwk.utah.edu; www.socwk.utah.edu.

Family Violence: Advocacy, Assessment, Intervention, Prevention, Research & Policy

This conference will bring together clinicians, advocates, researchers, program directors, and others to discuss new strategies in advocacy, assessment, intervention, evaluation, prevention and research of all aspects of family violence. Cost: To be determined.

DATE: September 23-27, 2000
LOCATION: San Diego, CA
SPONSORING AGENCY: Family Violence & Sexual Assault Institute, Children's Institute International, California School of Professional Psychology
CONTACT: Joe E. Marciano, M. A., Family Violence & Sexual Assault Institute. (858) 623-2777, ext. 406; marciano@mail.csp

Treating Women's Addictions: Research Confronts Reality

This conference will focus on the multi-dimensional treatment issues that have emerged for women affected by substance-related disorders and process addictions. Emphasizing cultural influences that exist in policy and practice, it will focus on 2 major topics: reducing risks in daily living and the relationship between trauma and addiction.

DATE: October 2-3, 2000
LOCATION: Binghamton, NY
SPONSORING AGENCY: Binghamton University and Broome Community College
CONTACT: Office of Professional Development and Research, School of Education and Human Development, Binghamton University, PO Box 6000, Binghamton, NY 13902-6000. (607) 777-4447; Fax: (607) 777-6041; angelone@binghamton.edu; seh@binghamton.edu; psydv/index.htm.

National Conference on Health Care and Domestic Violence

This conference will focus on health care's response to domestic violence by addressing continuing education, cutting-edge research, innovative practices and programs, and partnerships between health systems, government, providers, and domestic violence experts. The conference will also include culturally and linguistically relevant intervention strategies and will discuss

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health issues related to victims, perpetrators and communities affected by domestic violence. Cost: To be determined.

DATE: October 13-14, 2000
LOCATION: San Francisco, CA
SPONSORING AGENCY: The Family Violence Prevention Fund, National Health Resource Center on Domestic Violence
CONTACT: Peter Sawires, National Health Resource Center on Domestic Violence, 383 Rhode Island Street, Suite 304, San Francisco, CA 94103. (415) 252-8991; peter@fvpf.org.

Communities Respond to Drug Related Harm

This 3rd national harm reduction conference is a collaboration of community organizations, AIDS service agencies, advocates and scientists to create a lasting national dialogue on harm reduction. It will offer common ground to build the harm reduction movement and a chance to share the personal side of the work. Cost: before 8/15/00 $360 ($330 for members); after 8/15/00 $450 ($400 for members).

DATE: October 21-25, 2000
LOCATION: Miami, FL
SPONSORING AGENCY: Harm Reduction Coalition
CONTACT: Conference Coordinator, Harm Reduction Coalition, 22 West 27th St., 5th Floor, New York, NY 10001. Fax (212) 213-6582; hrc-conf@harmreduction.org.

National Conference on Addiction & Criminal Behavior

This event will provide information on addiction, intervention, criminal behavior, relapse and recidivism of criminal offenders. It will help participants to understand the lifestyle and value systems of criminal drug offenders, and learn strategies for treating addiction and criminal behavior and helping offenders develop a plan for re-engaging into society. Cost: $375 before 9/1/00; $400 after 9/1/00 (day rates $125-150).

DATE: October 22-25, 2000
LOCATION: St. Louis, MO
SPONSORING AGENCY: GWC, Incorporated
CONTACT: GWC, Inc., P.O. Box 5023, 530 Falling Spring Road, Cahokia, IL 62206. (800) 851-5406 or (618) 337-9300. Fax (618) 337-7880; mailto:info@gwcinc.com.

Tools that Work: Information Systems to Measure & Improve Services to Vulnerable Children, Youths, and Their Families

This 9th annual information technologies conference will enhance the competence of child welfare and behavioral health care practitioners in the area of information technology. Cost: To be determined.

DATE: October 23-25, 2000
LOCATION: Atlanta, GA
SPONSORING AGENCY: Child Welfare League of America Walker Trieschman Center
CONTACT: Kristen Wines, Walker Trieschman Center, 300 Congress St., Suite 305, Quincy, MA 02169-0907, (617) 769-4010; Fax (617) 770-4464; utc@cwla.org.

14th Annual Empowering Families Conference: Kicking It Up a Notch, Harmonizing with Families in New Orleans

This conference will discuss practice, policy, education, and research elements of forging true partnerships between family services providers and service consumers that empower families. The conference will also discuss federal, state and local policies that affect families. Cost: To be determined.

DATE: November 29 - December 2, 2000
LOCATION: New Orleans, LA
SPONSORING AGENCY: National Association for Family-Based Services
CONTACT: Jo Dickens, Center for Conference and Institutes, 100 Oakdale Campus, W310, The University of Iowa, Iowa City, Iowa, 52242-5000. (319) 335-4141.

Zero to Three’s 15th National Training Institute

This conference is intended for infant/family practitioners, educators and trainers, program administrators and supervisors, researchers and policymakers. Topics will include: discussion of the most critical issues affecting the development of children under three and their families, strategies for promoting best practices in infant/family services, and public policies that impact the birth-to-three population. Cost: To be determined.

DATE: December 1-3, 2000
LOCATION: Washington, DC
SPONSORING AGENCY: The National Training Institute, Meeting Management Services, Inc.
## RESOURCES AND PUBLICATIONS AVAILABLE FROM THE NATIONAL AIA RESOURCE CENTER

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