

# **PROJECT SAFE: INOVATIVE PRACTICES 2002**

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## Introduction

Concerns about the relationship between alcohol- and other-drug (AOD) related problems and the neglect and abuse of children grew during the early 1980s in Illinois. Child welfare workers became increasingly aware of the over-representation of AOD problems among the families they served, and addiction treatment providers increasingly lamented their inability to play a greater role in enhancing family health, and more specifically parent-child relationships, among their clientele. Discussions of these joint concerns led to the development of an innovative model of intervening in the lives of addicted women and their children. This model—known as Project SAFE—evolved from a small demonstration project to a program that today reaches families in communities across Illinois.

The purpose of this manual is to convey the history and current status of Project SAFE as well as to describe some of the best service practices within this model. There are three primary audiences for this report: 1) state addiction treatment and child welfare policy makers, 2) persons who currently, or in the future will, work within local Project SAFE service sites, and 3) other states and communities interested in innovative programs to address the confluence of substance abuse and child neglect and abuse. The chapters of this manual provide technical guidance to those working in project administration, outreach, curriculum development, parenting training, and addiction counseling. There is prescriptive material within the report that we hope will be beneficial to a wide range of health and human service workers who come in contact with addicted parents and their children.

Chapter One provides a history and overview of the Project SAFE model, and Chapters Two through Five successfully detail the

administration, coordination and training; engagement and outreach services; treatment services, and parenting and family service components of Project SAFE. The appendices include a summary of the research that supports Project SAFE model as well as other materials that illuminate the Project SAFE model.

In contrast to the earlier evaluation reports which focuses primarily on what the Project SAFE was able to achieve, this report attempts to describe how the project works. It provides a detailed description of both structural and process components of the project. Perhaps equally important, it captures the anecdotal observations, insights, serendipitous discoveries and the collective wisdom of all those who worked on the project. In this update of the original program manual, we have tried to elucidate the lessons learned as we sought to institutionalize across Illinois what had been a highly successful demonstration project.

This manual incorporates earlier material from Project SAFE reports and manuals and new information gathered at regional meetings (held in the fall of 2001) of those involved with Project SAFE. Staff from child welfare and addiction treatment agencies working together within 23 Project SAFE sites contributed to this manual (See Appendix One). Comments throughout this manual framed as "we recommend...", "it was our observation that...", etc. reflect areas of consensus or at least oft noted thoughts shared by staff during the evaluation and best practices discussions. Where differences in perceptions occurred between staff of the pilot sites and staff from the expansion sites, they are so noted in the report.

The problems of child neglect and abuse and the problems of alcohol and other drug

addictions have been addressed by a plethora of social agencies. The intensity of these problems as they interact has often overwhelmed the hopefulness of both service providers and service recipients. Amid the overall response of the administrative and bureaucratic structures which we as a culture have erected to respond to such problems, there sometimes emerges a program that has a special power to touch and transform lives. This manual is the detailed story of one such a program.

For those of us who have worked within Project SAFE since its inception, it has been one of the most challenging and rewarding experiences of our lives. It is our hope that the reader of this manual will get a better feel for the struggles and victories of the women and children of Project SAFE and the struggles and victories of the staff who, in entering into partnership with these women and children, made this such transformations possible.

## Chapter One:

### The Project SAFE Model: Executive Summary

#### 1.1 Program Inception

The causative and contributing roles of maternal alcohol and other drug use in the neglect of Illinois' children had long been a topic of conversation among protective service workers of the Illinois Department of Children and Family Services (DCFS). The Department decided in 1985 to take a more systematic look at this problem. Surveys of addiction treatment agencies in Illinois and direct service supervisors for the Department overwhelmingly documented the extent of the current problem and the failure of current service models to effectively intervene in this alcohol-related pattern of child neglect. As a result of the survey work and a review of both the child welfare literature and the addiction literature, a number of premises were formulated regarding the need for an alternative service models. It was concluded that such a system must include:

- joint planning, team-building and ongoing coordination at both state and local levels between addiction treatment and child welfare agencies,
- training for child welfare workers to recognize, understand, and motivate substance-involved mothers to seek help for alcohol and other drug problems,
- an alternative addiction treatment design that addresses the special needs of addicted women,
- special home-based supports to enhance treatment completion, recovery maintenance, and mother-child relationships,
- a concurrent focus on addiction recovery and the enhancement of parental functioning rather than assuming that quality of parental functioning will be

automatically achieved with the cessation of alcohol and drug use, and

- a strong evaluation component to allow for refinement and increased responsiveness of the service design to client needs and to enhance the future replicability of the project.

In response to this clarified vision of the problem, potential changes in service models were explored by DCFS and the Department of Alcoholism and Substance Abuse (now the Office of Alcoholism and Substance Abuse), which resulted in the conceptualization of a particularly innovative service delivery design. DCFS staff, after discussions with DASA project planning staff, authored a proposal to the Administration for Children, Youth and Families within the Department of Health and Human Services to pilot test this newly conceived model. An affirmative decision by DHHS in early 1986 to fund the pilot proposal marked the formal beginning of Project SAFE.

Project SAFE (an acronym for Substance and Alcohol-Free Environment) is an innovative approach to intervening in the lives of substance abusing women with histories of child neglect or abuse. The intervention model brought together the resources of multiple state and local agencies to identify and assertively recruit women into a coordinated program of addiction treatment, parenting training, and home-based outreach services.

The project was implemented in 1986 by the Illinois Department of Children and Family Services (DCFS) in cooperation and collaboration with what is today the Illinois Department of Human Service's Office of Alcoholism and Substance Abuse (DASA). DCFS is the state and federally mandated child

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protection agency in Illinois; OASA is the comparatively designated agency responsible for the planning, licensing, funding and monitoring of substance abuse prevention and treatment services in Illinois. The purpose of Project SAFE as initially conceived was to develop, demonstrate, evaluate and disseminate a model of providing services to mothers with a history of neglect and/or abuse of their children and who also had histories of alcohol- and other-drug-related problems.

The service model incorporated the following components:

- The identification by local DCFS Caseworkers of neglectful mothers who were screened to be at high-risk for alcohol- and/or other drug-related problems.
- The screening, assessment and recruitment of these individuals into an intensive outpatient addiction treatment program.
- The completion of a formal course designed to improve parenting skills.
- The provision of outreach worker services in the home to provide support for both sobriety and the application of new parenting skills.
- The on-going participation in self-help groups and aftercare counseling.
- Regular case conferences and service coordination meetings between local DCFS representatives and staff of the addiction treatment program.

The service model was piloted in three Illinois locations: Rock Island, Galesburg, and Dixon. Local DCFS staff and staff from collaborating addiction treatment programs met for training and project implementation planning in all three of these communities during the summer of 1986.

A fourth Project SAFE site in Peoria was added in 1987 with the intent of experimenting with more specialized services to children as

part of the SAFE service model. Between August 1, 1986 and June 30, 1988, 105 women and their children were involved in Project SAFE within these four pilot sites.

### 1.2 Outcome Evaluation

The 1986-1988 Project SAFE outcome study focused on the following three areas of client functioning:

1. Substance Abuse (Pre- and post-treatment patterns of substance abuse measured by client self-reports and the weekly in-home assessments completed by outreach workers)
2. Emotional Health (Pre- and post-treatment data collection that assessed the following dimensions of emotional health: self-esteem, anxiety and depression)
3. Parent and Family Functioning (Pre- and post-treatment data collection that assessed changes in mother-child relationship on the following dimensions: acceptance, over-protection, overindulgence, and rejection and weekly in-home family functioning assessment data recorded by the outreach worker Reunification rates and recidivism rates of reported abusing or neglectful behavior were also compared for Project SAFE participants and a control group of other DCFS clients.)

Data for women who participated in Project SAFE were compared with a control group of women who had histories of child neglect, but did not have histories of alcohol abuse or alcoholism. The results of the outcome study have been published in a separate manual (Evaluation Report: Illinois Child Neglect Services Project--White & Godley, 1988), and are summarized below.

The first finding was that the Project SAFE design was able to engage a heterogeneous client population in the service delivery process. Project SAFE clients represented

wide differences by age, ethnicity, marital status, living environment, and assessed risk of future abuse/neglect. Project SAFE was able to identify and treat a new population of addicted mothers, over half of whom had no prior history of either addiction or psychiatric treatment in spite of the level of problem severity at the time of admission.

Project SAFE clients had both high successful completion rates (81 percent) and high prognosis ratings upon discharge (51 percent left with an excellent or good prognosis as rated by the treatment staff). Mean scores on the Home Functioning Scale for Substance Abuse and post-test means on the Alcohol and Drug Use Severity Index demonstrated that Project SAFE clients were able to achieve a high degree of stabilization of early recovery and were able to extend this sobriety through the duration of the data collection period. Positive ratings achieved in this area included in addition to abstinence from alcohol, involvement in recovery support groups, contact with Alcoholics Anonymous and Narcotics Anonymous sponsors, and avoidance of situations that would pose high risk of relapse.

Post-treatment scores on the Self-Analysis of Anxiety Scale, the Personal Assessment Inventory and Home Functioning Assessment for Emotional Health Scale all suggest that Project SAFE clients experienced increased emotional health as a result of project participation. Clients experienced decreased depression, decreased anxiety, and increased self-esteem as measured by both client self-reports and weekly in-home assessments recorded by outreach workers.

Home Functioning Assessment for Parenting and Family Functioning and subscores on the Mother-Child Relationship Scale suggest that both the parent-child relationship and overall family functioning improved for Project SAFE

participants as indicated by both self-rating scales and by in-home observation and assessment by outreach workers. Project SAFE mothers were less rejecting in their attitudes toward their children after treatment than were the control group mothers to whom they were being compared. Improvements in parental functioning are further evidenced by looking at both reunification and abuse/neglect recidivism rates. Through participation in Project SAFE, 30 of the 55 children who had been removed from these mothers were returned home, for a reunification rate of 54.5 percent. The reunification rate for control groups was 40% for non-substance abusing women and 29.6% for substance abusing women within DCFS who were not involved in Project SAFE. The control group of non-substance abusing mothers experienced a 21.4 percent recidivism rate of subsequent child abuse/neglect reports. Women in the substance-abusing control group has a 92% recidivism rate for subsequent neglect complaints. In contrast, Project SAFE mothers experienced a recidivism rate of only 6.25 percent, which did not include any incidences of child abuse.

### **1.3 Project Expansion**

The positive evaluation of the four pilot sites led to the expansion of the project to an additional nine communities (catchment areas) in Illinois in 1989. This expansion was supported by assistance from the Alcohol, Drug Abuse and Mental Health Administration, Office of Treatment Improvement, who provide financial support for training and technical assistance to the new service sites. The nine Illinois communities targeted for SAFE expansion included: Chicago (2 sites), East St. Louis, Rockford, Aurora, Springfield, Decatur, Champaign, and Marion. These sites would include additional rural catchment areas as well as the first attempts to transfer SAFE to an urban

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environment the size of Chicago. During the year of site expansion, dramatic changes occurred in the nature of Project SAFE clients. The primary drug of abuse by SAFE clients shifted from alcohol to cocaine in all but one service site. The intensity of cocaine addiction forced treatment sites to alter the treatment structure to initially break the cycle of cocaine use and to prevent/manage relapse. Urban, cocaine-abusing women entering Project SAFE presented with a great number of personal and environmental obstacles to recovery (acute medical problems of client and children, housing/homelessness crises, transportation difficulties, legal problems, involvement in violent and treatment sabotaging relationships, etc.) than had earlier Project SAFE clients. These obstacles required intensified outreach worker services and a greater case management focus through the early phases of treatment. Structural adaptations included:

- Increased utilization of referrals for detoxification and residential treatment prior to initiation of SAFE involvement or for women who presented continued relapse.
- increased duration of intensive outpatient treatment (from 4-5 week model to 8-12 week model)
- increased frequency of contact (more in-home contact, weekend contact)
- phased transition from intensive outpatient treatment to aftercare and self-help (levels of decreasing care phased in over weeks, e.g., 20 hours to 15 hours to 10 hours to 5 hours to aftercare groups and self help only)
- extended period of total involvement with client (ideal time of total involvement seen as approximately one year)

More than 60% of SAFE clients served during 1989 and 1990 belonged to an ethnic minority. This required adaptations at many sites, e.g., staff training on cultural sensitivity, building relationships between treatment agencies and

persons and institutions in minority communities, refinements in some treatment protocol, and adaptations in the parenting curriculum.

There were additional changes in clients' psychological histories and the intensity of environmental obstacles to these clients' recovery. Project evaluators interviewed staff from the pilot and expansion sites in late summer of 1990 and prepared a revised Project SAFE Program Handbook based on the evolution of program design that had occurred in these sites.

In FY 1991, an additional three SAFE sites were established to meet the growing service demand produced primarily through a dramatic increase in the incidence of drug-exposed infants in the city of Chicago. Two SAFE sites were de-funded between 1989 and 1991, one due to low service utilization and the other at the request of the agency's board. Another Project SAFE site was added in Waukegan and began admitting clients in May, 1994. During FY 1995, four additional Project SAFE sites were added, all in the Chicago area, and two new SAFE sites were added in 2000. Today there are 23 Project SAFE sites operating in Illinois (See Map on next page).

### INSERT MAP

#### **1.4 Process Evaluations, the OASA/DCFS Initiative, and Other Collaborative Projects**

Four process evaluations were conducted on Project SAFE during the expansion beyond the first four service sites. The purpose of these evaluations was to document the continued evolution of the Project SAFE intervention and treatment model. These evaluations consisted of interviews conducted by the project evaluator with DCFS workers and staff of the

OASA-funded addiction treatment agencies at all of the Project SAFE sites and an analysis of demographic and clinical data collected on women served at each treatment site. Findings from these earlier evaluation reports that remain applicable have been integrated into this manual.

The cooperation between OASA and DCFS on Project SAFE was extended to several other activities, the most prominent of which was the OASA–DCFS Initiative, which began in 1995. This initiative heightened the access of clients of the child welfare system to gender-specific addiction treatment services. Service supplements included outreach services as well as transportation and child care services added to detoxification, outpatient, methadone, residential and inpatient modalities (See Guidelines for OASA/DCFS Initiative Programs, 1997). In 1998, researchers from the University of Illinois and University of Chicago completed an evaluation of the Initiative programs. This study concluded that clients in Initiative programs reported greater service access and utilization less drug use at follow-up. Other OASA-DCFS collaborations that enhanced the overall operation of Project SAFE included the training of more than 7,000 DCFS caseworkers and investigators and POS agency personnel during 2000 in the newly developed Substance-Affected Family/Substance-Affected Infants policy guide and service protocol. This was followed by a co-location project that sought to remove barriers to treatment by placing addiction treatment service staff at designated DCFS field sites during 2001. The goals of this project were to shorten the time between referral and assessment, increase admission rates to treatment, and improve communication between child welfare and addiction treatment service providers. OASA and DCFS staff also teamed up to conduct joint site visits of SAFE and Initiative sites to improve cross-site communication and service

planning and problem solving, and to host an annual leadership summit that brought together the fields of child welfare and addiction treatment. During Fiscal year 2000, \$22 million dollars was spent to support treatment for 11,426 clients involved in the child welfare system.

Programs that have operated in conjunction with and in tandem with Project SAFE include:

- The Families and Children in Treatment (FACT) Program which provides linkage to addiction treatment as well as employment and housing assistance.
- The Forever Free Recovery Home and Madison County Recovery Community which provide sober housing and various recovery support services for recovering women and their children.
- The Healthy FIT Program which provides addiction treatment services to pregnant women and new mothers receiving care within Sinai Health Systems in Chicago.
- Intact Family Recovery Program which provides integrated addiction treatment and child welfare services to mothers who have delivered a drug-exposed infant.

## 1.5 Project Staffing

The staffing of Project SAFE during its inception via the DHHS grant included a Department of Children and Family Services (DCFS) Project Officer and Project Director; an assigned Project Coordinator from the Department of Alcoholism and Substance Abuse (DASA) (now the Office of Alcoholism and Substance Abuse–OASA); and contractual employees who provided curriculum development, training and evaluation research services. Grant funds also provided resources for the direct service sites to hire outreach workers for the project and to provide specialized women's treatment services that had not been provided prior to the initiation of Project SAFE.

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The DCFS Project Officer supervised the overall administration of Project SAFE and, during the first three years of the project, assumed primary responsibility for liaison with DHHS and assured that all DHHS funding requirements and procedures were met. The DCFS Project Director had primary responsibility for program planning, project start-up, and day-to-day oversight of the project. All DCFS personnel who served in these roles were child abuse and neglect experts who worked in the Department's Office of Program Development and Support. These DCFS and DASA/OASA staff members played crucial leadership roles in encouraging on-going refinements in the SAFE service design in order to meet the special needs of the women served by the project.

The funding for each Project SAFE site provided for a Project SAFE Coordinator, one or more primary therapists, one or more outreach workers.

In FY 2002, the Project SAFE sites averaged 4.35 staff positions and experienced a 23% turnover within these positions during the fiscal year.

One third of the staff who work in Project SAFE sites are bilingual (Spanish).

### **1.6 Administration, Funding and Coordination**

The overall success of the implementation, operation, evolution and evaluation of a Project SAFE service design requires a high level of coordination and collaboration between substance abuse treatment and child protective agencies at state, regional and local levels. This coordination and collaboration must be actively created and managed through ongoing planning and team-building activities. State-level commitment and designated local

leadership are essential elements of project success.

While Project SAFE was initiated by a DHHS grant to DCFS, the project was, from its initiation, a collaborative effort between the state child protection and state addiction treatment agencies. DCFS and DASA (and later OASA) were integrally involved in every aspect of the project.

State-level coordination occurred first through the persons of the DCFS Project Director and a DASA staff person assigned as the Project SAFE Liaison. These individuals coordinated joint state-level planning regarding project's design, implementation and ongoing program refinement. They also played leadership roles in facilitating training and team-building between local DCFS offices and the local treatment agencies. Project SAFE involved coordinating multiple service components provided by different agencies within very diverse communities. Linking and integrating these service elements into a cohesive program of care was different for each community and required significant time and effort by the DCFS Project Director and the DASA Project Coordinator.

At the local Project SAFE level, two issues were paramount in project initiation: the integration of Project Safe into the local DCFS office and into the local treatment agency, and the development of coordination mechanisms between the DCFS office and the treatment agency. The change in thinking and operational procedures implicit in Project SAFE inevitably triggered resistance and had to be overcome via marketing of Project SAFE within each DCFS Office and treatment agency. The most important local inter-agency coordination linkages proved to be designating a Project SAFE coordinator at both the DCFS and treatment site and weekly case

conferences involving DCFS workers, treatment staff and outreach workers.

Policy-level coordination at the state level was enhanced through a OASA/DCFS Advisory Committee that was created as part of the OASA-DCFS Initiative. This Committee is chaired by the Governor's Chief Policy Advisor and has utilized subcommittees to address several policy implementation issues.

Planning and coordination activities within Project SAFE are described in Chapter Two.

### **1.7 Site Selection**

Project SAFE was pilot tested in four Illinois sites. The initial site selection criteria included the following:

1. The community had to contain a local DCFS office and a DASA licensed and funded substance abuse treatment program that included intensive outpatient services
2. Both the DCFS and treatment sites had to exhibit an administrative commitment to women's services in general, and to Project SAFE, in particular.
3. Priority was given to sites in which a key staff person has the desire and skills to assume a local leadership role in the project.
4. Priority was given to locations in which both the DCFS office and treatment agency exhibited an openness for innovation and creative problem solving and commitment to service responsiveness rather than to particular ideologies or models.
5. The site had to have the capacity for local parenting training utilizing the existing DCFS parenting curriculum.
6. The treatment program had to augment existing intensive outpatient services with specialized women's groups.

Conscious effort was made in the selection of expansion sites to include urban sites and to select sites that served primarily minority

women and women whose primary drug choice was cocaine. This selection process was designed to test the SAFE model on a much more heterogeneous client population.

It was discovered through the expansion sites that not all of the earlier noted characteristics must preexist for successful start-up. A number of these characteristics are in fact created or enhanced through the project orientation and start-up process. The project success hinges ultimately upon the attitudes, motivations and skills of front line child welfare and treatment agency workers as they engage clients in the change process. Support for these workers must be built in to the project so they see potential benefits and rewards that will accompany the extra effort demanded by the project. Supports we tried to create included access to high quality training, access to praise from project personnel and trainers, high visibility for staff actively involved in the project, opportunities to help represent the project at professional conferences, high camaraderie and cohesion among participating staff, and formal recognition and awards. These supports were particularly important in the expansion sites because there were additional new programs being initiated within DCFS concurrent to the Project SAFE start-up.

### **1.8 Training**

The initial training component of Project SAFE involved the design and delivery of an orientation and training curricula followed by on-site technical assistance provided to DCFS workers, addiction treatment staff and outreach workers. The seminars were specifically designed for cross fertilization of knowledge across disciplines. The training design sought to enhance the knowledge and skills of DCFS workers related to the assessment and treatment of substance use disorders in women and to increase the knowledge of addiction counselors in areas related to child abuse and

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neglect. Training events held in each local project site also brought DCFS and treatment staff together for team building, project orientation and development of local service implementation and coordination plans.

Key elements in an ideal training design for Project SAFE are now seen to include:

- Initial staff orientation (focus on project design orientation, role definition, relationship building across agencies, development of local start-up plans, and development of high level of motivation and esprit de corps)
- Initial staff training (focus on knowledge and skill building; skill training for specialty roles within the project)
- On-site technical assistance provided within 4-8 weeks of project initiation (technical assistance provided by key Project SAFE staff from existing sites)
- New staff orientation during service year (integrating both orientation and skill-building functions from above)
- Mechanisms for information sharing across sites, e.g., periodic symposia, newsletters, electronic/telephone networking, etc.
- An annual Project SAFE Symposia for information sharing, networking, and assessment of the on-going adaptations of the SAFE service model
- Opportunities for workers to meet for information exchange regarding special role functions, e.g., outreach, parenting training.

Training activities within the Project SAFE model are discussed in Chapter Two.

### **1.9 Treatment Services**

Following training and sensitization of local DCFS caseworkers on the signs and symptoms of substance use in women, workers began to screen women in their caseloads who were at high risk for substance-related problems. These potential problems were discussed with

these clients, the services available through Project SAFE were described, and clients were strongly encouraged to make contact with the project. Initial referral for outreach worker contact with resistant clients often predated and contributed to the client's formal entry into treatment. Where problematic alcohol/drug use was blatant and clearly linked to neglectful behavior, the encouragement of caseworkers and outreach workers was sometimes supplemented by constructive coercion from the local courts.

After assessment and intake into the local Project SAFE substance abuse treatment program, each woman participated in the development of an individualized treatment plan that met her unique needs and the needs of her family. Each woman was assigned a primary counselor responsible for oversight and delivery of counseling services. Treatment planning addressed multiple problems and regularly involved joint staffings by DCFS and the treatment staff as well as other community resources.

Treatment activities included substance abuse education, individual and family counseling, specialized women's groups, skill-building activities, and participation in mutual aid groups. The women who today participate in Project SAFE averaged 16-20 hours of structured intensive outpatient treatment services for an average of 38 weeks. Prior to discharge, a continuing care plan is developed with each client detailing the on-going activities she plans to participate in as part of her long term recovery process. There is a recent trend toward greater utilization of recovery homes by Project SAFE clients and their children.

It was essential that addiction treatment services within Project SAFE be designed to meet the specialized needs of addicted women and, more specifically, the specialized needs of women who shared the unique characteristics

of Project SAFE clientele, i.e., poverty, childhood sexual abuse, co-occurring psychiatric disorders, chaotic and toxic intimate relationships. Treatment staff working with Project SAFE over the past sixteen years have been forced to rethink many of their ideas about the nature of addiction and recovery. The development of new understandings and new treatment technologies within Project SAFE have potentially broad application to the treatment of women and other client groups who have not historically responded to traditional approaches to addiction treatment. Chapter Four provides a detailed discussion of treatment procedures used within in Project SAFE.

### **1.10 Outreach Services**

Outreach workers are assigned to work with each woman referred to Project SAFE. In what would come to be seen as a crucial, and the most innovative, component of Project SAFE, outreach workers maintained almost daily contact with each client, serving multiple roles of motivator, nurturer, advocate, role model, resource broker, counselor, chauffeur, surrogate family member and friend. Aggressive outreach services, which moved out of fashion in the addictions field in the 1980s, were the hallmark of Project SAFE. Such services were based on a provocative premise: Service interventions which might be pejoratively labeled "rescuing" or "enabling" for addicted men, may be essential ingredients in initiating and sustaining recovery for a significant portion of addicted women. It was the outreach worker who helped the client integrate Project SAFE teachings on sobriety, emotional health and effective parenting into each client's day-to-day lifestyle outside the treatment setting. The outreach workers came to be viewed as the glue which helped bond together in practical applications the various strands and elements of the Project SAFE experience. There is unanimous belief by everyone associated with Project SAFE that

its success would not have been possible without the outreach worker service component.

The experience with the particular brand of outreach services utilized within Project SAFE was so significant that some aspects of these services could be christened as a new treatment intervention or modality. What is most promising is the ability of this modality to reach clients whose internal resistance to change and environmental obstacles to recovery have historically resulted in failed engagement, premature disengagement, and chronic relapse (defined both in terms of sustained drug use and child neglect). The future evolution of this model must encompass the development of specialized personal and professional supports to sustain outreach worker health and effectiveness in this intense service context.

Project SAFE continues to demonstrate that aggressive outreach worker services can initiate and sustain treatment involvement with women who have been historically labeled hostile and treatment-resistant. The ways in which such outreach services are provided is described in Chapter Three.

### **1.11 Parenting Training**

Every woman who participated in Project SAFE completed at least 16 hours of training to enhance the quality of her parenting skills. The training utilized a variety of standardized curricula that were modified by many of the sites for increased cultural sensitivity and individual appropriateness. The practical application of effective parenting principles was reinforced through the presence of outreach workers in the client's home. Such presence allowed outreach workers to serve as parenting consultants to clients as situations arose with children in the client's home environment.

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The view that an expanded focus on service to children (including older teenage children) must evolve within the Project SAFE model continues to grow. There is also a perceived need for more family-focused therapy seeking to reconstruct (or build for the first time) healthy relationships between family members, with a particular focus on the mother-child relationship.

The parenting training and children's and family services offered within Project SAFE are described in Chapter Five.

### **1.12 Evaluation**

An independent contract for evaluation research was executed so that the outcome of the Project SAFE service design could be formally and independently evaluated. The evaluation plan involved two broad elements: 1) a formal outcome study to assess the changes experienced by women participants as a result of their involvement in Project SAFE, and 2) a process evaluation examining project start-up, refinements that occurred in the design and delivery of services and recommendations of staff related to future replications of the project. The outcome study followed Project SAFE clients admitted in the first four sites between July, 1986 and July 1988. Process evaluations (involving the debriefing of key personnel involved with Project SAFE) occurred during 1988 with the original SAFE sites, in 1990 with the original SAFE sites and nine expansion sites, and in 2001 with all existing Project SAFE sites. Meetings with Project SAFE sites to update changes in the model and to identify best practices were conducted in 2001 and form the basis of this report.

Evaluation and research components of a Project SAFE must be designed to evolve and adapt with refinements in the service delivery process. Such refinements should not be prevented in the name of maintaining purity of research methodology. Evaluation activities should include process as well as outcome elements.

### **1.13 Summary**

Between 1986 and 2002, the Illinois Department of Children and Family Services and the Illinois Department of Human Service's Office of Alcoholism and Substance Abuse implemented, evaluated and widely replicated a unique model of addressing the problems of substance-effected families. Today, the multi-agency teams that make up the twenty-three Project SAFE sites in Illinois treat more than 2,200 women and their families per year.

There is every indication that the coordinated and concurrent delivery of specialized addiction treatment services, parenting training, intensified casework services and in-home outreach worker supports can be effectively combined to successfully treat addicted mothers, to enhance family and parental functioning and to reduce the neglect of children. The evaluations of Project SAFE recommend the wide replication, continuing refinement and ongoing evaluation of this innovative service model. Project SAFE continues to be viewed by DCFS workers, local child welfare agencies, and addiction treatment site staff as a highly innovative and effective approach to substance-effected families. There is a growing body of knowledge within this project that may have transferability to many other areas within the child welfare and addiction treatment fields

## Chapter Two: Administration, Coordination, and Training

### 2.1 Introduction

Three conditions seem to define the major administrative challenge faced by Project SAFE.

Complex, multidimensional problems often require complex, collaborative solutions. The administrative structure of Project SAFE has been based on collaborative principles and practices. This is its overwhelming strength and, at times, its area of greatest challenge. Even the strongest structure will experience some vulnerability at the places where its many parts are joined:

- It is difficult to run complex, collaborative programs in an atmosphere of scarcity. Judging from the focus groups and interviews conducted during the 2001 evaluation process, the commodities in greatest scarcity are time (in terms of personnel hours dedicated to the activities required for coordination and collaboration), shared information among the various systems involved, and the training and cross-training to inform and support these activities. The overall effect of this scarcity is the danger of delay or interruption of services at several key points along the way.
- Given the average client's level of psychological vulnerability and ambivalence about treatment, any delay or interruption of services has the potential to derail the process. Many clients and potential clients live at the center point of an array of intense and often-opposing pressures. For example:

- They are torn between their love for their children and the physiological and psychological imperatives imposed by substance abuse and addiction.
- The thought of entering treatment and learning to live without alcohol and other drugs threatens the only sense of security they know, while the failure to comply with all of their DCFS mandates threatens their connection with their children.

Financial pressure to comply with welfare-to-work requirements is a powerful competitor for their time, in spite of their need for treatment services and their mandate to complete those services.

It is this delicate and often precarious balancing act that the administrative and coordinating structure of Project SAFE seeks to guide and resolve by bringing child welfare and substance abuse treatment systems together in a unified, knowledgeable human front that can help remove the obstacles to treatment access, engagement, completion, and long-term success.

### **This chapter**

1. Briefly describes the structures and mechanisms of collaboration within Project SAFE.
2. Discusses some of the current challenges to those structures and mechanisms, including training and cross-training needs, and
3. identifies some possible solutions and best practices for administration, coordination, and training.

## 2.2 Structures and Mechanisms of Collaboration

The OASA/DCFS Initiative that grew out of the collaboration set in motion by Project SAFE now provides funding and administrative services to 33 substance abuse treatment agencies whose services reach DCFS-involved men, women, and youth at 73 sites throughout Illinois. Of those agencies, 23 host Project SAFE sites. The following is a brief and general description of the structures (organizational assignments of responsibility) and mechanisms (general practices) that have been established for interagency coordination of Project SAFE services.

### Administrative and Coordinating Structures

Responsibility for interagency coordination of Project SAFE exists primarily at the state and local levels, with the DCFS regional offices serving a supplementary role.

#### *Statewide*

Within DCFS, responsibility for administration and coordination of the Initiative falls on the AOD Manager and the AOD Coordinator, in the Department's Division of Health Policy. On the OASA side, the OASA Manager of the OASA/DCFS Initiative holds primary responsibility for administration and coordination. These three individuals both model and promote successful collaboration through their day-to-day efforts and their staffing of the OASA/DCFS Advisory Committee. While the DCFS AOD Manager focuses primarily on policy and program development, the DCFS AOD Coordinator and the OASA Manager of the OASA/DCFS Initiative collaborate on program and contract monitoring and the many problem-solving, team-building, training, and technical support needs that arise at the regional and site levels. They also monitor and

support compliance with the 1999 Substance-Affected Family/Substance-Affected Infants policy.

The statewide OASA/DCFS Advisory Committee establishes policies and procedures for the Initiative as a whole, and for Project SAFE. It includes representation from DCFS, OASA, the many community agencies that provide child welfare services through contracts with DCFS (called Purchase of Service, or POS agencies), Prevent Child Abuse Illinois, and the substance abuse treatment agencies in the Initiative. The Committee meets on a quarterly basis and is regularly attended by the Directors of both DCFS and OASA. Co-Chairs of that committee are the OASA Director and the Deputy Director of DCFS's Division of Health Policy. Subcommittees meet quarterly or more often and address a range of issues including best practices, training, and the Title IV-E Child Welfare Initiative.

For Project SAFE and the other Initiative services, substance abuse treatment services are funded under OASA contracts. DCFS funds auxiliary services such as child care, outreach, and parent training.

#### *Regional Level*

Illinois is divided into six DCFS regions, covering:

- North
- Central
- South
- Cook County North
- Cook County Central
- Cook County South

Regional involvement in training, team-building, and coordination was at its strongest during the project's demonstration phase (1986-1988), and was reduced in subsequent years. However, in 2001 the Administrator of each DCFS region selected one administrative

staff member to study and define the issues at work in Initiative programs within the region, and to develop an action plan to address issues of collaboration and resource building on a regional basis. Information for the plans are to be developed and disseminated through regional meetings designed to take place at least on a quarterly basis, with representation from the local DCFS field offices and DCFS-contracted child welfare agencies, substance abuse treatment sites within the Initiative, and a variety of resource agencies within their communities. The six administrative staff members responsible for these plans will also be responsible for monitoring contract compliance in Initiative sites, and some have already taken over those monitoring duties. All six are also on the statewide OASA/DCFS Advisory Committee. In addition, the DCFS regional offices can serve as a source of information and assistance for Initiative agencies that are unable to obtain the information they need from the local DCFS field offices.

### ***Local Level***

A critical element at the local level is the effectiveness of interagency coordination and collaboration between the Project SAFE treatment site and the child welfare offices (DCFS and POS) referring clients for services. Although many case workers and treatment staff members are involved in the day-to-day workings of Project SAFE, the project's history has shown that successful coordination requires that one person in each organizational entity have primary responsibility for interagency coordination.

- At each Project SAFE treatment site, one person is designated as the single liaison/point of contact for the program. A variety of titles (e.g., Project SAFE Coordinator, Program Manager, Team Leader) are associated with this position, which is often occupied by managerial or supervisory personnel. Respondents to the

2001 Project SAFE Survey reported that all sites have a designated liaison serving as a focal point for communication and problem-solving with DCFS and other child welfare agencies.

- Each local DCFS field office has a liaison with primary responsibility for interagency coordination with Project SAFE and other Initiative sites. The liaison, who may be a case worker or a supervisor:
  - enhances awareness and provides information to the case workers about the substance abuse treatment services available to their clients,
  - provides encouragement and technical assistance to case workers on matters of referral and interagency coordination, and
  - serves as a point of contact for treatment staff who need additional assistance in the referral and coordination process.

Survey respondents at 76 percent of the Project SAFE sites reported the existence of a designated liaison at their local DCFS field offices.

- The POS child welfare agencies have no designated liaisons on staff, because the funding has not been available to support that role. The liaison role is in the process of being filled by 11 prevention resource developers (PRDs), employees of Prevent Child Abuse Illinois (the Illinois Chapter of the National Committee to Prevent Child Abuse). The prevention resource developers have a variety of inter-agency functions, including:
  - locating and marketing AOD treatment and other services for clients within POS agencies;
  - providing encouragement, training, and technical assistance to POS child welfare providers in the referral process; and

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- promoting communication and collaboration between child welfare and substance abuse treatment agencies and personnel within the OASA/DCFS Initiative.

The PRD positions were created in November, 2000 under a contract with DCFS, funded through the federal Community-Based Resources and Support Grant. The PRDs have spent much of their first year being trained and oriented, establishing relationships with the many agencies whose work intersects theirs, beginning the process of acquainting the POS agencies with the services that are available to them, and beginning the process of providing training and technical assistance to POS agencies.

### **Processes of Referral and Coordination**

Although the practices vary somewhat from site to site, and there is no “typical” Project SAFE client, family, or case, the following sequence describes the general steps laid out for referral of clients to the Project and interagency coordination concerning the client.

#### ***The DCFS or POS Case Worker***

- identifies a potential problem with alcohol and/or other drugs (AOD) in a client;
- conducts a simple screening to confirm that potential, using the DCFS Form 440-5 screening tool;
- tells the client about Project SAFE and gives the client contact information for the local SAFE treatment site;
- asks the client to sign a consent form authorizing the child welfare and treatment agencies to exchange information regarding the client’s case; and
- completes referral paperwork (including the Form 440-5 screening tool; the consent form; a referral form; and a Law Enforcement Agency Data Services sheet, if this sheet is available for this client) and

sends that paperwork to the local SAFE treatment site.

#### ***The Project SAFE Outreach Worker***

- makes initial contact with the client, if the client has not made such contact;
- conducts one or more home visits (if needed) to increase the client’s level of comfort with the idea of going to treatment, and to identify any obstacles to treatment involvement (ideally, the first home visit should be attended by the child welfare case worker as well);
- arranges for an assessment of the client’s treatment needs (or conducts the assessment, in the few cases in which the outreach worker is clinically certified);
- if and when the client enters treatment, helps the client adjust to the transition; and
- remains involved in the client’s treatment process, helping the client solve problems and address obstacles to treatment, and in some cases filling a case-management role.

#### ***Treatment Staff***

- provide treatment services;
- provide parent training;
- refer the client to any internal (within the agency) or external (within the surrounding community) services necessary for the well being of the client and family;
- report to the child welfare case worker on the client’s progress in treatment;
- participate in regular meetings and staffings with child welfare staff; and
- participate in special meetings with child welfare staff to respond to any crises or special needs that might arise.

#### ***The DCFS or POS Case Worker***

- participates in regular meetings and staffings with treatment staff;
- participates in special meetings with treatment staff to respond to any crises or special needs that might arise;

- as necessary and appropriate, becomes involved in referral processes for the well being of the client and family; and
- attends the graduation ceremony when the client completes the program.

### **Mechanisms of communication and collaboration**

A variety of formal and informal practices have been established that allow communication between treatment child welfare staff on the needs and progress of Project SAFE clients. They include:

- Informal or unscheduled contact
- Colocation
- Joint staffings
- Formal clinical case management
- Family meetings
- Regional meetings
- Technical assistance
- The Statewide SAFE Conference

### **These practices are briefly described as follows:**

#### Informal or unscheduled contact

At the local level, much of the onus for collaborative effort rests on staff of the Project SAFE treatment sites. In order to attract enough clients to make SAFE IOP groups and parenting classes financially viable, the sites rely on referrals from DCFS and POS. Many sites have established patterns of frequent (e.g., weekly or semi-weekly) informal or unscheduled visits to DCFS or POS offices, where they can market Project SAFE to case workers and supervisors, discuss cases already in progress, receive any new referrals, and be available to answer any questions that child welfare staff might have.

#### Colocation

Recognizing that the physical presence of SAFE treatment staff in child welfare offices tends to increase communication and

collaboration, OASA initiated and funded a colocation program as part of the Initiative in 2001. Through this program an employee of a SAFE treatment site works full time within the local DCFS office. That employee does not provide treatment (an off-site exception license would be necessary for the provision of treatment services there), but fulfills a number of formal and informal functions for interagency coordination and communication. These functions often include marketing Project SAFE, facilitating the referral process, conducting early intervention services, assisting child welfare staff with screening, and conducting assessments. Thus far there are three Collocated workers in the Initiative, two of them with Project SAFE sites: Prairie Center in Urbana and Rosecrance in Rockford.

#### Joint Staffings

A multi-agency Project SAFE staffing brings together child welfare workers, outreach workers, treatment staff, and workers from appropriate allied agencies to:

- plan home visit and intervention strategies for clients who are resisting project involvement;
- share and discuss data related to client history, level of participation, client problems and obstacles to participation, and the welfare of children and families;
- plan and coordinate services for women who might be involved in several concurrent service projects, (e.g., Families First, Drug Free Families with a Future, mental health counseling, etc.); and
- appropriately time and prepare for the reunification of Project SAFE mothers and their children.

#### Formal Clinical Case Management

This term applies to a process in which treatment and outreach staff fully and regularly collaborate in case management, through consistent attendance at joint staffings. In formal clinical case management, the sharing

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of information is comprehensive, and each agency (child welfare and treatment) has full knowledge of the other's work requirements and with the client.

### Family Meetings

SAFE treatment and outreach staff can be invited to DCFS family meetings for SAFE clients. These meetings may be convened on an as-needed basis to discuss the case. They may include the client, family members who have been helpful or supportive and/or can help with the children, the case worker, the case worker's supervisor, AOD treatment staff, and representatives from other agencies involved with the client (e.g., domestic violence workers).

### Regional Meetings

The AOD coordinator in each region is expected to convene a meeting at least once per quarter, including representation from local DCFS field offices, POS child welfare agencies, and Project SAFE treatment sites. These meetings address a variety of topics, including ways of improving regional and local coordination, specific treatment planning problems, challenges of serving multiple-problem families, ways of increasing referrals, ways of raising awareness of AOD-related problems, and basic collaboration and coordination among the many services within the community needed by this population. In addition, other regional meetings may be held that have relevance for and might appropriately include Project SAFE staff.

### Training

Across-the-board training and orientation for Project SAFE staff was an important element of the project's start-up phases, but for several years the responsibility for training has largely been assigned to the individual agencies. At the Project SAFE treatment sites, the training of new staff and the ongoing development of existing staff are responsibilities of the site

itself. Within DCFS and POS agencies, new case workers participate in a 2.5-day Foundation training, of which one abbreviated module generally addresses AOD issues. After the DCFS policy guide on Substance-Affected Families was published in November, 1999, DCFS and POS workers received more extensive AOD training in the Substance-Affected Families/Substance-Affected Infants training, conducted in 2000. Out of that training and the work of the prevention resource developers and the DCFS AOD Coordinator has also come a training resource notebook for case workers called "Everything You Ever Wanted to Know About AODA Referrals But Were Afraid to Ask." Some additional training for case workers is also being delivered by the PRD workers, DCFS, and the staff of some Initiative treatment centers.

### Technical Assistance

Technical assistance is another area in which the formal system-wide efforts seen in the start-up phases of the project are no longer available. Substantial portions of the DCFS AOD Coordinator's and the OASA Manager's roles are devoted to technical assistance in a variety of forms, from situation-specific trouble-shooting/problem-solving efforts to more concentrated examination of systems and practices. Other OASA staff also may contribute technical assistance, such as the intensive technical assistance provided to one SAFE site by OASA's Administrator of Women and Youth Services, who was a central figure at the inception of Project SAFE. Prevention resource developers have also begun to provide technical assistance to POS agencies.

### The Statewide SAFE Conference

The annual statewide conference has been part of this project since the beginning. The Project SAFE Conference that took place in the project's early years was expanded in 1995 to

include other OASA/DCFS Initiative programs. Most of these conferences have brought together DCFS and POS workers and counseling and outreach staff from the SAFE sites for the sharing of technical information, practical tips, and mutual support. In 1999 the Initiative convened a statewide Leadership Summit on Child Welfare and AODA issues. 2001 (FY2002) was the first year in which the Initiative did not hold a statewide conference, with the funds instead given to the regions for regional conferences and other activities. Two regions did conduct annual conferences; the rest used the funds for smaller-scale meetings and collaborations held on a more frequent basis.

### **Case Management and Service Linkages**

Beyond the primary collaboration between treatment and child welfare agencies, SAFE staff must also coordinate with the wide range of public and private agencies whose services are necessary to sustain clients and their families, remove obstacles to treatment participation, and support treatment success. These may include:

- intra-and inter-agency referrals for needed treatment and counseling services (e.g., detoxification, residential treatment, child care, health care, family services, domestic violence counseling, additional counseling services for the client);
- linkages with community agencies that can supply goods or services needed by clients and families (e.g., housing, skill training, financial aid, literacy, GED, job readiness, etc.); and
- coordination with other public service systems (e.g., Public Aid, Criminal Justice) that often have requirements or mandates that the clients must fulfill.

In large, comprehensive treatment agencies, internal referrals for needed services are often the easiest and most acceptable to both the clients and the agencies themselves. Smaller

agencies with more limited services often grow adept at finding appropriate services within the community and forming relationships to support their referrals. Depending on the services and the need, DCFS or POS staff may also be instrumental in the search for appropriate referral targets, and DCFS may fund the necessary services.

As neurologically vulnerable and emotionally overwhelmed as many Project SAFE clients are, coordination with other public service systems has proved to be a critical need in case management. It can be difficult for clients to address the requirements of treatment alone. With the addition of DCFS timetables for family reunification, back-to-work timetables to satisfy Temporary Assistance to Needy families (TANF) requirements, and the stress and confusion of criminal justice involvement, many clients' schedules and mandates can seem to take legitimate priority over substance abuse treatment, serve as an excuse to quit treatment, or function as powerful relapse triggers. Clients need help in understanding the many requirements, sorting through their priorities, negotiating requirements with the various agencies, and navigating the often frightening and confusing meetings and hearings that are necessary to their survival and continuation in treatment.

At Project SAFE sites, primary responsibility for case management often falls on the Project SAFE coordinator. At sites that have implemented an aggressive outreach approach, outreach workers may be filling case management roles. In smaller sites with fewer resources, this role may be assigned to Counselors or other personnel. As mentioned above, some sites share formal clinical case management with DCFS or POS case workers, to reap the benefit of combined strength and resources.

So far this chapter has focused only on the structures and mechanisms established to

promote and maintain inter-agency coordination, communication, and collaboration. The following discussion addresses some of the challenges that have faced these structures and mechanisms and their effects on the project and its people.

### **2.3 Challenges to Collaboration**

In the focus groups that contributed to the information-gathering process for this report, much of the conversation focused on the challenges inherent in a collaborative interagency structure such as that of Project SAFE. The treatment and child welfare representatives' comments pointed to a number of areas of increased vulnerability in the process, including:

- the identification and referral process;
- situations in which the needed services and supports are not available, resulting in obstacles to treatment engagement and/or completion;
- information gaps between the local treatment and child welfare agencies; and
- transitions from one service source or service level to another.

Stress at any one of these points of vulnerability can result in a lack of needed services, and/or in the client's disengagement from the treatment process. A number of challenges that contribute to this stress will be examined for three of the categories described earlier in this chapter:

- regional coordination
- local processes of referral and coordination,
- mechanisms of communication and collaboration, and
- case management and service linkages.

#### **Challenges to Regional Coordination**

After the demonstration phase of Project SAFE, regional involvement in training, team building, coordination, and improvement of

SAFE services was decreased. The selection of an administrative staff member (sometimes called the regional AOD coordinator) in each region to provide leadership for the Initiative in that region is a fairly recent phenomenon, and some of these staff members have had only a little time to begin to gather information, meet with all agencies, and develop their plans. The progress has varied greatly from region to region, depending on:

- the length of time the regional AOD coordinator has occupied that position,
- the amount of time that person has available to devote to this effort,
- the number of regional meetings that have been held and the level of participation in those meetings, and
- the level of initiative taken by the regional AOD coordinator.

Meetings involving DCFS and POS agencies, SAFE sites, and other local resources are meant to take place on at least a quarterly basis. Most meet quarterly, one meets on a monthly basis, and one region met once and has not held any subsequent meetings.

The regional AOD coordinators also have some program monitoring responsibilities, including quarterly meetings with each Initiative site in the region to determine contract compliance and oversee fiscal decisions. Most of the regional coordinators have taken over these responsibilities (although the statewide AOD Coordinator still fulfills these functions in those regions in which the regional coordinator is still too new to that position). Their level of effectiveness in this role varies from region to region, based on their level of skill and initiative in asking questions, suggesting solutions, and providing support for the program-development process.

#### **Local Challenges to Referral and Coordination**

In Project SAFE, the referral process may be

the most crucial link between child welfare and substance abuse services. According to the focus group discussions, that link also suffers considerable stress in many areas. Some of that stress springs from the sheer magnitude of the need for services and the overall DCFS/POS caseload, and some from issues of personnel retention, mobility, and training. Effects of these issues include:

- Cases not being referred or being lost in the system, or never making it into the system
- Referrals not being supported by the paperwork necessary for the initiation and funding of services
- Difficulties in identifying case workers and liaisons

### ***Identification***

Identification of potential child welfare cases, the first step in the process, is also the first weak link. One focus group participant in the Southern region noted that many people refrain from calling the DCFS Hotline, and that people who do call might be treated badly and required to give information that they may not have. Also in that region some hospitals, a major source of identification of substance-exposed infants, are failing to conduct drug tests or failing to report their results unless cocaine is present. On the other hand, in some areas identification of substance-exposed infants has increased, according to treatment staff from the Northern region. Identifications, which used to come in at a rate of one or two per month, have increased to two or three per week.

Staff from the two Southern region sites also expressed frustration about the need for services similar to those provided by Project SAFE among some men, some women who are not involved with DCFS, some women whose DCFS cases had been closed prematurely, and some women who meet the

criteria but are not being referred for SAFE services.

### ***Investigation***

Another stress point begins when the information about a potential case has been received and the DCFS Division of Child Protection (DCP) has begun the process of investigating the problem and opening the case. At that point the Investigator (now called the Child Protection Service Worker) has 60 days to complete the investigation, and does have a responsibility to link the client to appropriate services even while the case is being investigated. Until the case has been opened and assigned to a DCFS or POS case worker, it is still officially assigned to the Investigator.

However, some focus group participants reported difficulty in obtaining information from DCP about cases and case assignments. One participant said she had been told by a DCP Investigator that a particular case was in a “limbo” state between DCP and DCFS or POS files. As one DCFS regional representative contended, “As soon as the case is open and in the system, there’s an opportunity for it to get lost.” She said that there is no adequate tracking system to flag and bring to supervisory attention those cases for which referrals would be appropriate but have not been made.

### ***DCFS Staffing and Training Issues***

As stated earlier in this chapter, DCFS liaisons are either case workers, with full and sometimes overwhelming case loads, or supervisors with full supervisory responsibilities. The liaison function places additional stress on positions already overloaded with stress. And like most highly stressful positions, these experience considerable turnover and transfer of workers from job to job. With each lost employee, that employee’s knowledge and experience of

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Project SAFE and of the particulars and status of specific cases is lost. With each new employee, new training issues arise, issues that are difficult to address in a highly mobile and overburdened work force.

Case workers will refer clients appropriately for services under Project SAFE and make informed and appropriate decisions throughout the clients' involvement in the project – only if those workers:

- are well aware of the program and apply that awareness to their consideration of each individual child welfare case,
- know enough about Project SAFE to consider it an effective option,
- know enough about substance abuse and addiction to understand their pivotal role in family stress and child abuse and neglect,
- are adequately trained to screen potential candidates,
- understand the referral process well enough to navigate it and have sufficient knowledge of the required paperwork to complete it correctly and in a timely manner,
- understand the recovery needs of the Project SAFE population well enough to consider those needs in all decisions related to the case, and
- are sufficiently well motivated to perform all these functions in the midst of all the other demands of their highly stressful positions.

The net effect of these staffing and training issues can include decreases in attention, effort, case identification, monitoring, and control where SAFE cases are concerned. Many focus group participants cited difficulties in obtaining the necessary referral paperwork from child welfare staff and mistakes in the completion of that paperwork. Some mentioned cases in which child welfare staff seemed unaware of the forms that had to

be completed and of methods of obtaining those forms.

Participants in some areas also reported difficulty finding and obtaining the appropriate DCFS contacts and follow-up on cases within the DCFS system. Staff from one treatment site spoke of being transferred from person to person, then being told that the case worker had retired. In the three Cook County regions, staff from most of the SAFE treatment sites reported difficulty identifying and contacting their DCFS liaisons.

### ***Referrals and Coordination in POS Agencies***

In the POS agencies, the problems identified above exist to even greater degrees. The POS agencies have no funding for liaison positions, so the prevention resource developers are in the process of assuming that role for those agencies; however, there are only 11 PRDs statewide; much of their first year has been taken up in orientation, training, and establishing relationships with the service providers; and they have not yet been able to bring their services to all of the POS agencies in their service areas. The PRDs also work with a variety of service systems, and have other duties in addition to their liaison functions in Project SAFE. In this transition period the benefits of having the PRDs assume the liaison role have not yet materialized fully and cannot yet be assessed.

Lack of referrals and referral paperwork from POS agencies, and difficulty obtaining information from these agencies, was a major problem identified in all the focus group discussions. Referrals from POS agencies make up a significant proportion of the referrals needed so that services can be provided to the families that need them, given that POS agencies handle an estimated 74 percent of the open cases statewide. Of the 23 agencies responding to the Project SAFE 2001

Survey, 86 percent reported that POS agencies made regular referrals to Project SAFE.

***Feedback from Treatment to Child Welfare***

DCFS and POS personnel are not the only ones whose heavy case-loads can cause disruption in the referral and coordination process. One DCFS regional representative cited problems when outreach workers failed to respond to referrals by POS agencies. Another contended that DCFS personnel may not receive adequate feedback from SAFE sites on the progress of the clients they have referred for treatment, and that this can lower their investment in Project SAFE. “The workers look at referrals as just more paperwork,” she said.

Asked about the information on treatment progress that is reported to DCFS/POS workers, survey respondents named a wide variety of types of information. The following list recounts (verbatim) the information reported to DCFS/POS workers, and the number of sites reporting each type of information (where no number is listed, only one site reported it):

- Attendance = 15
- Drug screen results = 14
- Client treatment progress, or lack of progress (client problem area) = 11
- Participation = 5
- Attitude = 5
- Observation of parent behavior = 5
- Continuing care plan = 3
- Diagnosis (results of assessment) = 2
- Outreach attempts and results = 2
- Referrals to other community resources = 2
- All 6 ASAM = 2
- Level of care = 2
- Psychiatric and DV info. = 2
- Dates of engagement – Treatment
- Discharge summaries
- Recovery environment issues
- Significant treatment issues
- Basically all

- Status of children attending with mother
- Medication compliance
- Area for progress
- General comments
- Any and all info the client allows us to release
- 12 step attendance
- Number of sessions
- Barriers
- Family/friend concerns
- CJ Involvement
- Life style changes
- Problems
- Needs

Asked about their standard method of communicating this information to DCFS/POS workers, the largest number of sites (14) reported communicating by phone. Of the other sites, 8 responded that they used written forms of communication, seven said they communicated face-to-face, and four reported that they communicated by fax. The medium in which the information was conveyed also varied, as follows:

- Staffing = 9
- Report = 6
- Progress Report = 5
- Attendance Report = 4
- Family Meetings = 4
- Form
- Exit Counseling

Asked about the frequency with which they communicated this information, only two sites said they communicated on a daily basis. Four sites reported that they communicated weekly, and nine said they communicated on a monthly basis.

The final result of all of the training, staffing, referral, and coordination issues that exist in Project SAFE extends far beyond increased frustration for child welfare and treatment staff. Every “lost” case, every delay, every disruption in services represents an

opportunity for the denial, fear of change, and reluctance to accept help that addiction fosters in any population, but particularly in one whose wounds are so deep and so wide.

### **Challenges to Mechanisms of Collaboration**

The time and staffing constraints described above also constitute the greatest challenge to the formal and informal mechanisms that have been established to maintain communication and collaboration between treatment and child welfare services. Through the focus group interviews and the surveys completed by treatment sites, some information was collected regarding the frequency and effectiveness with which these mechanisms are being used. Information is presented in three categories:

- Routine contact
- Joint meetings and staffings
- Case management

#### ***Routine Contact***

Both the focus group discussions and the interviews with the project administrators revealed that frequent, routine contact between treatment site staff and DCFS or POS staff is crucial both to the survival of the site (in terms of obtaining referrals and referral paperwork) and problem solving/information sharing for case management purposes. Those treatment sites that maintain a frequent or regular presence in child welfare offices (e.g., visiting these offices once or twice a week and meeting with child welfare staff) either through formal collocation, through the informal modes of collocation that some sites have devised, or through a regular visiting schedule have far less trouble obtaining referrals and meeting whatever challenges may arise.

However, it was clear from these discussions that not all sites initiate frequent routine contact with child welfare offices. Telephone contact is more frequent and more universal.

Three challenges seem to limit the amount of routine contact:

- Distance can pose obstacles, particularly in rural areas. Some sites have reported that most of their contact is made by telephone.
- Where no formal collocation exists (and formal collocation is present in only two SAFE sites), routine contact depends on the initiative of the SAFE treatment staff, and it is difficult for staff to sustain this degree of initiative when staff time is scarce. A few sites have even been located in the same building, or in buildings adjacent to those of DCFS offices, and still had infrequent or unsatisfactory contact with them until state-level staff intervened and helped them forge those linkages.
- Taking initiative in interpersonal and inter-agency networking and program marketing is a skill in and of itself, and not one often addressed in training and development in the substance abuse field. Some sites may fall short in their routine communication with DCFS and the POS agencies simply because they have not had sufficient training, preparation, and identification of incentives for this process.

Where there is formal collocation, certain conditions must be in place to render the collocation effective. For example, the collocated worker must be in the general stream of processes taking place in the DCFS office, rather than in an office isolated from the rest. And the office must be one that sustains a fair amount of client and caseworker traffic, rather than one whose primary work is accomplished off-site.

#### ***Joint Staffings and Other Meetings***

The weekly joint staffings that proved so valuable during the early years of Project SAFE became increasingly difficult to sustain, beginning as early as 1993, due to increased use of services at the treatment sites, increased time demands on DCFS workers, and more regular day-to-day communication between

the outreach workers and DCFS workers. Turnover of staff, resulting in periods of under-staffing and staff overload in Project SAFE and the local DCFS offices, has strained the ability to conduct case conferences on a consistent basis. For example, in the 2001 Project SAFE Survey only 71 percent of SAFE sites reported that POS agencies participated in clinical case conferences. The median number of SAFE/DCFS/POS agency case conferences reported in the previous 30-day period was 7.6. An increasing amount of communication is being handled through written reports and by telephone (survey respondents reported an average of 20 phone contacts per week between Project SAFE and DCFS/POS agencies). This lack of sustained, intensive interagency contact makes joint formal clinical case management impossible in many sites.

Although the focus group discussions did not collect all-inclusive data on the activities conducted by the many agencies on the treatment and child welfare sides, when asked to volunteer information about their methods of coordination with DCFS and POS:

- Five out of 23 sites reported that they hold regular meetings with DCFS
- Four sites reported monthly meetings with DCFS and/or POS agencies
- One site reported that it conducts formal clinical case management with DCFS (but not with POS agencies)
- Four reported holding meetings that involved treatment staff, DCFS, and the client
- Four reported having SAFE staff attend DCFS staffings
- Two reported holding staffings with all of the client's service systems
- Two reported that SAFE staff were invited to DCFS family meetings
- One reported that SAFE staff were invited DCFS conferences
- One reported that SAFE staff were invited to some DCFS Administrative Case Review meetings

- Three reported holding meetings with DCFS as needed
- One reported having a job-shadowing program with DCFS
- One reported that DCFS was invited to exit counseling sessions at the SAFE site

Although it is likely that some sites that did not report attending one or more of these types of meetings had in fact attended them, the low numbers of sites reporting joint meetings gives some indication that these mechanisms of communication and coordination may be under-utilized in many areas. At the state level, both DCFS and OASA have emphasized the need for joint meetings and frequent contact between the two systems at the local level, and have provided encouragement and incentives for increased contact. However, it may be that, even when large service systems make the structural modifications necessary to create truly collaborative programs, some staff members continue to think and act in terms of their individual agencies' traditional requirements and practices.

There seems in general to be a higher concentration of joint meetings in the Central region than in the other DCFS regions. It is not clear whether or not there is a connection between this and the fact that the project's earliest sites were in the Central region, so the earliest sites received higher levels of training and technical assistance because the program was in an experimental phase and funds were available for those preparatory measures. The Central region also does not experience the issues of distance that the Northern and Southern regions experience.

### **Case Management and Service Linkages**

As challenging as case management may be when it is applied to the complex, overwhelmed, and overburdened lives of Project SAFE women, that function meets an additional challenge when it is only one duty

## Project SAFE

among many for an already overloaded Project SAFE coordinator or outreach worker. At sites that have implemented aggressive outreach approaches, there is a trend toward the assignment of case-management duties to outreach workers, a natural fit given their involvement in so many aspects of clients' lives. However, many outreach workers' duties also include home visits, transportation to treatment and needed services, and introduction to recovery support systems; and in a few cases may include assessments (if the outreach workers are appropriately certified), urine testing, child care, parent training, and/or support in aftercare.

Case management duties may include internal and external referrals for counseling services outside the scope of the site's Project SAFE services, coordination with the various agencies whose requirements the clients must fulfill, and building linkages with local agencies that provide goods or services needed by the clients and their families. Following are some of the challenges that may arise in these areas:

- Large and diverse agencies can meet many of their clients' needs with internal referrals. However, many smaller, resource-poor agencies whose clients need services such as detoxification or residential treatment must refer clients to other Project SAFE sites for those types of services. When clients have received those services and are ready for standard Project SAFE Intensive Outpatient (IOP) programs, they often elect to stay at the larger sites rather than return to the smaller sites to which they were originally referred. This reduces the SAFE census at the smaller agencies, which often have fewer resources to sustain their programs while they wait for more referrals.
- An essential element of case management is the coordination and negotiation of clients' schedules and requirements with

the other agencies (e.g., DCFS, DHS Public Aid, Criminal Justice) whose mandates and requirements often compete with their treatment and recovery needs. The most common example of this is the preponderance of women who are required to seek employment under Welfare-to-Work policies, with work schedules that prevent their attendance at IOP and parenting groups. Most of the sites reported this as a major challenge to treatment engagement, retention, and scheduling.

- Another common example is the legal requirement that issues of permanence (whether or not children will be returned to their parents) must be settled within nine months of the date of case adjudication (decreased from 12 months under prior legislation). The nine-month period is scheduled at the State's Attorney's discretion, and may start as soon as the DCFS case is opened, long before the client enters treatment. This can result in a sense of urgency and haste that is counterproductive to treatment goals, and a desire to rush clients through treatment when in fact they may need many months' involvement just to become engaged in the treatment process. Clients may be forced to end treatment prematurely, setting them up for future relapse.
- Linking clients to services within the community is another essential component of case management, one that faces its greatest challenges when the services are not available. The area of greatest scarcity reported by focus group participants was safe housing and shelter to combat the problem of homelessness, particularly in the Northern, Central, and Southern Illinois Regions. Often clients' living situations are unsafe, transient, permeated with AOD and drug-selling cultures, and peopled with family members and paramours who sabotage treatment goals. Obstacles to safe housing include:

- the lack of shelters and recovery homes for women, most notably for women with children, particularly older children;
- the presence of alcohol and other drugs and drug cultures in many shelters;
- high demands on existing domestic violence shelters;
- sabotage of treatment goals among some mission-based shelters;
- the scarcity of Section 8 certificates for subsidized housing;
- rules that block access to Section 8 for people already living in public housing; and
- the difficulty that clients have raising money for deposits on rooms or apartments in recovery homes and other settings.

In addition, some sites reported a scarcity of domestic violence services, difficulty in coordinating with local domestic violence shelters and counseling services, and some domestic violence shelters' policies that prohibit services to women who have substance abuse problems. A few sites also reported difficulty in finding appropriate child care.

In spite of these considerable obstacles, Project SAFE continues to foster large and small improvements in the lives of hundreds of families each year. The following section outlines some of the methods and practices that have been found most successful in meeting these challenges and promoting successful collaboration, communication, and coordination of services; and recommendations for meeting the challenges that remain.

## 2.4 Recommendations and Best Practices

The following discussion of program recommendations and best practices will address four major areas:

- Administrative and coordinating structures, including state-level administration,

regional coordination, the liaison system, and the referral system

- Mechanisms of communication and collaboration, including routine contact and joint meetings
- Case management
- Training

### Administrative and Coordinating Structures

#### *State-Level Administration*

In this category a discussion of best practices might amount to a review of the practices that have taken place in Project SAFE thus far.

State Leadership: The Directors of both DCFS and OASA have exhibited a firm commitment to Project SAFE from its earliest days.

Leadership of both agencies has been committed to the belief that a highly coordinated service-delivery design using the resources of both departments offers unique opportunities to disrupt the cycles of substance abuse, deterioration in parental functioning, and child neglect. The repeated references to Project SAFE by agency leaders during meetings and in professional speeches has both evidenced and generated great support for the project. This support has paved the way for smooth project implementation, communicating to everyone concerned that all obstacles that stand in the way of the success of this project must be confronted directly and resolved.

Advisory Committee: The active leadership role taken by the OASA/DCFS Advisory Committee is also a critical element in the project's success. Strong and regular involvement in the Committee by the Directors of both agencies sends a clear message of joint ownership of the project. The focused work of the subcommittees, sometimes meeting more often than once in a quarter, has ensured that policy is reviewed and crafted in a manner that is responsive to the needs of Project SAFE

families and the smooth functioning of the project as a whole.

Coordinating Agency Staff: Regardless of the procedures that have been established for inter-agency coordination, and the incentives that have been extended, state officials have often found that the most effective way of promoting collaboration and communication is case-by-case, one-to-one on-site problem solving and technical assistance by the OASA Manager and the DCFS AOD Coordinator. Just as the treatment and child welfare staff's success in collaboration often rests on individual relationship-building efforts, so does the success of the project leaders' efforts. The fact that this team represents both the child welfare and substance abuse authorities in the state has provided a significant resource for problem solving in local service design and delivery issues.

As a result of these activities the OASA Manager and the DCFS AOD Coordinator have also often found themselves advocating internal changes in policies and procedures at the state level that would make Project SAFE workable and more effective at the local level. Their shared responsibility for representing the project and facilitating project meetings has sent a strong message of collaboration since the project's inception. This equality of ownership in the project has eliminated the competitiveness and the "win/lose" problem-solving approach that can sometimes characterize attempts at multi-agency collaboration.

### ***Regional Coordination***

The wide range of success that the individual DCFS regions have reached in their oversight and planning processes points to one central recommendation in this area:

- use the region that has achieved the greatest success (Cook Central) as a model for best practices;
- study and quantify the steps taken by that

region, the timelines within which those steps have been taken, and the skills and processes that have contributed to the region's success;

- identify and assess the challenges to successful coordination that exist in each region and ways of meeting those challenges; and
- use that information to develop and provide training and technical assistance to all Regional AOD coordinators, designed to bring all regions up to the best-practices standard.

An additional recommendation concerns a procedure for gradually building involvement in the quarterly regional AOD meetings. The first session might involve only DCFS and POS staff, providing information and networking opportunities in AOD concepts and the services available to their clients. The next session would add participation by staff of Project SAFE sites, providing cross-training and additional networking opportunities. When this network is established, representatives from the many ancillary services and resources available within the communities would also be included. Representatives from criminal justice systems (e.g., judges and state's attorneys) would also be valuable participants in this process.

### ***Liaison System***

DCFS Liaison System: Three recommendations would address ways of approaching best practices for the DCFS liaison function.

- Quantify and assess the DCFS liaisons' case loads and ability to perform SAFE liaison functions, analyzing the data on local, regional, and statewide levels, and make staffing, training (e.g., time management), and role-assignment recommendations based on that analysis.
- Provide more liaison-role-specific training, technical assistance, and job-shadowing opportunities for DCFS liaisons.

- Collect from the various regions information about the most effective procedures for identifying and contacting DCFS liaisons and case workers (including the liaison role that Regional DCFS staff can play when local liaison positions experience rapid turnover, the information that the public service administrator at the Case Assignment Unit can provide on case worker assignments, and the use of the child protection service worker as the point of contact when cases are in transition between DCP and the DCFS case worker); publish statewide, regional, or local procedures, depending on whether or not the procedures vary from location to location; distribute those procedures to SAFE treatment sites; and update the procedures as the systems change.
  - **POS/PRD Liaison System:** Three recommendations for this system as well:
    - Since the prevention resource developers' liaison roles for the POS child welfare agencies have not yet been fully implemented, the first recommendation would be to implement that relationship in full, assess its effectiveness, and make any adjustments indicated by that assessment process.
    - SAFE treatment sites should also be given information about the contract oversight role of the Agency Performance Teams, including the potential use of these teams to intervene in cases in which neither direct contact with the case worker and supervisor nor coordination and technical assistance from the prevention resource developer has succeeded in resolving coordination problems.
    - Cross-training for prevention resource developers, POS case workers, and SAFE site staff in liaison functions will also be an essential component of success.
- Referral System: According to the focus group participants and interviewees, the best practice, rapid referrals and accurate and complete referral paperwork followed quickly by assessments, is not the norm at this point. Participants pointed to a number of recommendations for improving this system in troubled areas.
- Activities are needed that would raise the awareness and understanding of Project SAFE among DCFS and POS case workers, so that the program would come to mind when they encounter cases that are appropriate for referral. In the 2001 Project SAFE Survey, one site recommended the use of “intensive outreach” to locate DCFS/POS workers who could make referrals.
  - To identify and address the cases that warrant but do not receive SAFE referrals, two measures were recommended: 1) begin the design of tracking capabilities within the DCFS computer system that would flag these cases and bring them to the attention to the appropriate staff, and would track eligible cases throughout their lives in the system; and 2) as a temporary measure, implement on a regional basis informal tracking measures that would help identify cases that are not being referred appropriately. For example, one regional DCFS representative asked all her offices to make a list of all cases eligible for but not receiving SAFE services, obscured the clients' names but included the case numbers and case workers' names, and distributed the list to the SAFE sites so that they could take the initiative to follow up.
  - Provide increased and task-specific cross-training for all staff (DCFS, POS, PRD, and SAFE) who participate in the referral system. Include standards, timelines, and appropriate practices for follow up (by both child welfare and treatment staff); detailed, step-by-step instructions in filling out referral paperwork (e.g., the DCFS “Everything You Ever Wanted to Know

About AODA Referrals But Were Afraid to Ask” training); procedures that SAFE staff can follow to elicit timely and accurate referral paperwork from child welfare staff; and time management techniques related to the referral process.

To address the need for more effective identification of potential cases of child neglect and abuse, participants in an information-gathering process sponsored by Prevent Child Abuse Illinois suggested greatly increased public awareness and education. DCFS Hotline staff might also be trained in customer-relations skills, and medical providers might receive more training in identification and reporting of substance-exposed infants..

### **Mechanisms of Communication and Collaboration**

#### ***Routine Contact***

In terms of routine contact between SAFE treatment providers and child welfare agencies, the overall best practice is to have as much and as frequent contact as necessary, not only to facilitate the referral process, but also to provide ongoing feedback and promote joint case management. Four recommendations might work toward making this a reality.

- Formal and informal colocation was clearly identified as a best practice, wherever sites take full advantage of that colocation. In formal colocation, ensure that treatment staff are situated in high-visibility areas, become part of the flow in child welfare agencies, and become involved in all the ways that are appropriate to those situations. In informal colocation, promote ingenuity and initiative in making and sustaining regular contact among a variety of systems (e.g., AOD treatment, child welfare, public aid, domestic violence, criminal justice).

- More frequent formal and informal contact between Project SAFE and DCFS/POS staff is essential to successful communication and collaboration. Many respondents to the 2001 Project SAFE survey cited frequent phone and in-person contact as a best practice for this project.
- There is a need for more team-building activities and incentives on a regional level involving substance abuse and child welfare staff.
- The collaborative site-level problem-solving work of the DCFS AODA Coordinator and the OASA Manager for the OASA/DCFS Initiative constitutes a best practice in fostering increased contact and collaboration between local child welfare and treatment sites.

#### ***Joint Staffings and Other Meetings***

The overall best practice in this area, recommended by administrators and line staff alike, is a true process of ongoing collaborative clinical case management by treatment and child welfare staff, facilitated through the consistent multi-agency attendance of joint staffings, family meetings, and designated multi-agency meetings. This would be supported at the regional and state levels through meetings, conferences, training programs, and other networking and information-sharing venues. This goal might be approached beginning with seven basic recommendations.

- Continue to hold the annual statewide OASA/DCFS Initiative conference, including tracks for specialized functions such as outreach and parent training.
- Hold region-wide multidisciplinary meetings as well, either in the form of an annual conference or in the form of more frequent, shorter meetings, depending on the needs and time constraints in that region.
- On a site-by-site basis, collect data about the staffings and other meetings that take

place within individual agencies, the frequency with which those meetings receive multi-disciplinary attendance, the joint meetings that do take place, and obstacles to multi-agency participation in case management. Analyze this data by site, by region, and for the state as a whole, identify unfulfilled opportunities for collaboration, and release the resulting report to local and regional child welfare and SAFE sites.

- Develop a streamlined, automated system for cross-agency notification of the times and dates of meetings related to SAFE clients, and make that system available to the regional offices and local child welfare and SAFE sites.
- Explore opportunities for periodic multi-site meetings of outreach workers, within schedules that their other requirements would allow.
- Provide tips for SAFE treatment staff and child welfare staff in the appropriate use of interagency meetings as cross-training opportunities.
- Encourage involvement of SAFE staff in meetings of the DCFS Local Area Networks (LANs).

### ***Case Management and Service Linkages***

While the ideal is a fully collaborative multi-agency case management process, several measures can be taken to strengthen the case management processes that are taking place within the SAFE treatment sites.

- A logical first step would be to gather information on the assignment of case management roles and responsibilities as they exist, the other responsibilities also held by case managers, and any challenges they face in fulfilling the case management role. Based on the results of that information-gathering process, support and training could be offered where it is needed.

- Promote formal and informal multi-agency collaborative efforts to examine multi-agency demands on clients.
- Provide greatly increased opportunities for cross-training on addiction, treatment, and the recovery needs of this population, targeting the many service systems whose services and/or requirements have an impact on Project SAFE clients.

## **2.5 Training**

### **Training Issues**

#### ***Selected child welfare/Substance Abuse training***

#### DCFS SAF (Substance Affected Families) Policy and Practice Training Course

The DCFS Substance-Affected Families policy was developed in 1999. The following year, all DCFS and POS<sup>1</sup> agency staff attended the SAF Policy and Practice Training Course. The purpose of this training is to “provide DCFS and POS direct service staff with best practice information and skills to serve as substance-exposed infants and substance-affected families from initial contact through case closing.” (DCFS, 1999). The DCFS “SAF” training is divided into five modules:

1. SAF/SEI<sup>2</sup> Protocol Overview
2. The First 30 Days
3. Family Intervention
4. Evaluating Progress in Placement-Reunification Cases
5. Preparing for the Termination of Parental Rights

#### Project SAFE Annual Conferences

Each year from 1987 through 2000, a statewide Project SAFE conference was held. Participants in this conference have included clinicians, outreach workers, and

<sup>1</sup> POS (purchase of service) agencies are those that provide child welfare services under contract to DCFS

<sup>2</sup> Substance-exposed Infant

administrative personnel from the Project SAFE treatment provider agencies as well as a wide range of DCFS staff members (e.g., DCFS/Project SAFE liaison staff, caseworkers and administrators). These conferences have provided a opportunity for participants to learn from a wide variety of speakers and workshop leaders, review the development of the Project SAFE system, identify programmatic problems, concerns and challenges, and identify solutions. In addition, skills training was provided for different disciplines within the Project SAFE network. For example, addiction treatment providers were given an opportunity to learn about child welfare issues, such as how to identify abusive situations during home visits. In CY 2001, Project SAFE regional conferences were held.

Lighthouse Institute/Illinois State University Training Projects

Lighthouse Institute and the School of Social Work at Illinois State University, both together and separately, have implemented four child welfare training projects since 1994. More than 500 individuals involved in child welfare and/or substance abuse work have been trained as the result of these programs. The four projects were made possible by grants from the U.S. Department of Health and Human Services, Administration for Children, Youth and Families. The four training programs are listed below.

1. **Women and Children First.** (October 1994-February 1996) provided training on the related issues of substance abuse and child maltreatment to 270 child welfare and substance abuse treatment workers, other community professionals, judges and physicians in a series of workshops held at nine locations throughout the state of Illinois.
2. **Project Next Step** (October 1995-December 1997) provided a series of competency-based training modules and

curricula that addressed the problems of substance abuse affected families within the child welfare system. These products were used to provide primary education for both undergraduate and graduate social work students, and to enhance the competency of social work professionals already practicing within the field. Approximately 120 individuals received this training.

3. **Project Safe Families.** (October 1997-September, 2000) involved curriculum development and delivery of a series of competency-based training modules that addressed the impact of substance abuse, domestic violence, and mental illness on child welfare. These products were used to provide both introductory and advanced training to 150 child welfare professionals in Illinois.
4. **Project Strengthening Supervision.** This project which began in October 2000 is designed to 1) support the policies, practices and changes that are occurring within the child welfare field as the result of ASFA and other recent federal and state legislation, 2) to improve the decision-making process among child welfare supervisors and their staff in cases where parental substance abuse is an issue, and 3) to enhance the ability of clinical supervisors and their staff to conduct permanency planning in cases in which substance abuse is an identified problem. Four days of training are being provided to groups of 20 clinical supervisors in three separate regions of Illinois each year. The four days address the following topics. Subtopics, if applicable, are indicated for each day of training.
  - Introduction to the Transtheoretical Stages of Change and Motivational Interviewing.
  - Advanced Substance Abuse Issues-Day 1

- Understanding the ASAM Patient Placement Criteria, 2<sup>nd</sup> Edition-Revised
- The Drug-Exposed Infant and Child: Research Update
- Client Methamphetamine Use and Manufacture: Ensuring the Safety of Child Welfare Workers
- Issues in Relapse Prevention
- Advanced Substance Abuse Issues-Day 2
- Promoting Recovery and Safety within Substance Affected Families
- Methadone: Facts and Myths
- Supervising for Maximum Effectiveness



## **Chapter Three: Outreach Services**

### **3.1 Introduction**

If the collaborative structure of Project SAFE works as a sort of central nervous system for the program, then the outreach function may be its heart and soul. All but one Project SAFE site (Human Resources Development Institute, located in Chicago) employ 1-2 full-time (or full-time equivalent) outreach workers. The median caseload for outreach workers is approximately 18 clients. Their duties vary from site to site, as does their level of responsibility and involvement in clients' lives, but their primary purpose is to build, protect, and sustain the engagement that is essential to treatment completion and successful recovery. This chapter looks at several aspects of outreach, including:

- the evolution of outreach in Project SAFE,
- the range of outreach services,
- the engagement role of outreach ,
- the outreach worker,
- current and ongoing issues affecting the outreach role, and
- best practices and recommendations for outreach .

### **3.2 The Evolution of the Outreach Role**

The original conception of outreach in Project SAFE was formulated as a practical solution to the logistical problems that prevent many low-income women, particularly women with children, from attending intensive outpatient treatment, e.g., the lack of transportation and the lack of child care. However, some of the most important discoveries in Project SAFE have happened more through serendipity than by design.

During project initiation, outreach workers kept contacting substance-abusing, highly treatment-resistant women because there were

no other duties for the outreach workers to perform until clients were admitted. Through this programmatic twist of fate, it was discovered that sustained outreach worker contact with change-resistant clients broke down this resistance and increased the likelihood of their entry into treatment. The implications of this discovery are profound and extend far beyond the boundaries of Project SAFE.

The “aggressive outreach ” that has become an ideal in Project SAFE covers both this relentless initial engagement process and a dogged willingness to press for the woman’s and the family’s recovery and survival needs – even when that means dispensing more honesty than the client is ready to accept. But paradoxically, some of the most conspicuous skills of an effective outreach worker are patience, love, respect, empowerment, and persistence.

Since the mid-1990s, some sites have diverted their outreach focus toward a role that might be described as “clinical outreach.” There has been increased allocation of outreach worker time to assist in the direction of on-site treatment activities, particularly those which are child- and family-focused. Clinical outreach reflects a shift in the outreach worker's role from the details of outreach to the relationships and processes involved in outreach. It focuses more on the role of the outreach worker as a change agent in the life of the client. The more clinical focus that some outreach workers are taking on is reflected in such activities as conducting or assisting with client assessments and intakes, presenting lectures and facilitating discussion groups within the SAFE treatment schedule, and spending more time conducting home visits and providing supportive counseling to clients

in aftercare. In some cases outreach workers have even assumed formal or informal case management roles, coordinating activities among the various service systems at work in clients' lives.

As one reads the literature that has documented Project SAFE through the years, interviews administrative and line staff involved in all aspects of the project, and reviews the best practices cited by respondents to the 2001 Project SAFE Survey, one striking feature emerges: the extremely high value that all concerned place on the outreach role and the workers who occupy that role. The information that follows can only begin to capture the essential functions that outreach fulfills, and some of the reasons for the high esteem in which this relatively humble role is held.

### 3.3 Outreach Activities and Roles

According to data from the 2001 survey of Project SAFE sites:

- Approximately 59 percent of current clients received home-based outreach services before their admission to Project SAFE.
- Approximately 22 percent of current clients received a joint visit by outreach workers and child welfare workers to engage them in Project SAFE.
- For the current clients who have had home-based outreach services, an average of three outreach visits were required to enlist their involvement in the program.

#### Outreach Activities

The responsibilities of outreach workers have evolved by design somewhat differently across the project sites. The most consistently performed duties and responsibilities of outreach workers include the following:

- assisting in the initial encouragement and engagement of the client in Project SAFE;
- providing transportation for clients to and from treatment (19 agencies provide this), and in some cases to and from other needed services;
- visiting Project SAFE clients in their homes, before, during, and (in some sites) after their direct involvement in treatment;
- providing in-home consultation on parenting and child care issues;
- formally or informally assessing the obstacles to the client's participation in treatment;
- assisting Project SAFE mothers in arranging day care services, so that the mothers can be free to participate in intensive outpatient substance abuse treatment services;
- serving as a welcoming presence, and at some sites providing rituals of welcoming and support, when clients first arrive for treatment;
- helping the client integrate into the home and transfer at a practical, behavioral level the lessons learned in treatment and parenting classes;
- assisting and supporting the client in restructuring relationships and building a lifestyle conducive to long-term recovery;
- providing aggressive support to manage the crises that arise during early recovery and often lead to disengagement from treatment, and to relapse;
- providing ongoing emotional support to clients in order to enhance their sustained involvement with Project SAFE, often augmenting support at the most vulnerable times, like transitions in treatment services;
- linking each Project SAFE client with those self-help groups that are most clinically appropriate and geographically accessible to her; and
- participating in staffings with treatment staff and DCFS workers, to ensure

coordination and consistency in client service delivery.

In some sites, outreach roles have expanded in a variety of directions. For example, outreach workers have taken over responsibility for urine drops and breathalyzer checks in several sites. In addition, outreach workers in some sites have increased their role in follow-up and aftercare services as the pool of graduated Project SAFE clients has increased. Telephone calls, home visits, and transportation to self-help meetings are also important elements of aftercare support provided to Project SAFE clients by outreach workers in many sites.

### **Outreach Roles**

Before looking at outreach services as the initial stage of client treatment, it is important to elucidate what outreach services are not. Outreach workers are not simply glorified cab drivers, babysitters, and hand-holders. They are not advocates with a narrow focus on the procedural rights of the client. They are not simply case managers linking motivated clients to needed services. They are change agents who use the vehicles of service linkage, advocacy, transportation, and babysitting to build relationships with addicted women and to instill in these women the desirability and possibility of change.

The formal evaluation that took place in the experimental phase of Project SAFE did not isolate the role of outreach workers as an independent variable so that comparisons could be made between the treatment outcomes of those clients who did and did not have outreach worker services. In spite of this lack of objective data, however, there was a consistently expressed belief by project clients, DCFS workers, and treatment staff that the outreach workers were one of the most important ingredients, if not the most important ingredient, in the project's success.

The following discussion summarizes themes that have surfaced during staff interviews about the importance of outreach workers to Project SAFE.

Although the outreach workers for Project SAFE have performed a large assortment of activities that have enhanced the personal recovery and parental effectiveness of project participants, the following appear to be the most critical.

**Motivator:** outreach workers who in the earliest design of Project SAFE were not even envisioned as having a role prior to admission to treatment – have frequently proved to be the most crucial ingredient in motivating women to enter the project. It has only been the repeated phone contacts and home visits by outreach workers that have turned some problem-denying, hostile, treatment-resistant women into Project SAFE success stories.

**Advocate:** Whereas DCFS and treatment staff tend to be viewed in authority roles, clients perceive the outreach workers in more neutral or advocacy roles. This is one distinct advantage to having the outreach worker identified as an employee of the treatment site, rather than by the child welfare agency. As the first Project SAFE staff person to establish trust with the client, the outreach worker forms a bridge or pathway to more trusting relationships with DCFS workers and treatment staff. Depending on the scope of the individual outreach worker's duties, this advocacy role may be extended into the client's involvement in other systems, such as the criminal justice system.

**Problem-Solver:** The outreach workers are aggressive problem solvers, attacking any obstacles that might prevent or minimize client participation in Project SAFE. The very process of problem solving and success at resolving such issues as child care and

transportation, among others, often generates the first experience of hope for project clients. This not only effectively eliminates obstacles that might otherwise have prevented or prematurely terminated client participation in the project, but also serves as an excellent problem-solving teaching process. Home visits also provide many opportunities for problem solving, when clients mention or outreach workers notice conditions or practices that may be unsafe or inappropriate.

**Confidant:** outreach workers are almost always the first Project SAFE staff with whom clients establish a relationship of trust. Admissions that are particularly painful or shameful to clients are often shared first with outreach workers. Self-disclosure of childhood sexual abuse, for example, is almost always shared first with an outreach worker, who in turn encourages the client to share such information with her counselor or treatment peers. Often the transportation process offers safe opportunities for intimate conversation, a sort of “van therapy,” the value of which is legendary throughout the program.

**Role Model:** The outreach workers are people with whom clients can identify. They often serve as role models for effective parenting, and outreach workers in addiction recovery become role models for successful recovery. The presence of the outreach worker provides a concrete demonstration of how Project SAFE principles work in daily life.

**Nurturer:** As children, most Project SAFE clients experienced patterns of emotional deprivation, neglect, and abuse in their relationships with their own parents. Project SAFE challenges mothers to take on behaviors and attitudes toward their own children that most of these mothers have never experienced. outreach workers often mirror the desired mother-child relationship characteristics in their own relationships with Project SAFE clients. There is a dimension of re-parenting

that often occurs in the outreach worker-client relationship. It is through the outreach worker relationship that many Project SAFE mothers often experience healthy patterns of nurturing, listening, emotional self-disclosure, limit setting, and problem solving. For outreach workers who are also involved in providing transportation or other services to clients’ children, the nurturing role is expanded. outreach workers can serve as role models and sources of affection, stability, and security for the children as well.

**Cheerleader:** outreach workers provide a constant source of “strokes” and support for client participation in Project SAFE. They exhibit “bold faith” in the client’s ability to change and constantly reinforce that such change can and will happen.

**Confronter:** outreach workers regularly confront self-defeating patterns of thought, feeling, and behavior that might otherwise abort or undermine client involvement in Project SAFE. It is the aggressive support and gentle confrontation by the outreach workers that often sustains client involvement in the project. The “I refuse to give up on you” stance of the outreach workers has often kept women engaged in the project who have histories of many aborted efforts at treatment but no history of successful treatment completion.

**Lifestyle Consultant:** How does someone live without alcohol and drugs when the people, places, and activities of daily life have been increasingly shaped by those substances? outreach workers help project clients disengage from this alcohol/addiction-oriented lifestyle and help them redesign an alternative lifestyle to fill the vacuum. The outreach worker links clients with a culture of recovery. Within the self-help community clients can find relationships, places, and activities that can help build a lifestyle around sobriety and emotional health.

Through all of these duties and roles, outreach workers become a consistent thread that follows clients through the pretreatment engagement process, the multiple levels of treatment services, the many efforts to find help in the community, and the service systems that often seem so intimidating. The result of this consistency is often a slow building of confidence and trust.

As outreach workers move closer to formal or informal case-management roles, they become integral parts of the treatment team, and of the collaborative communication and coordination structure of Project SAFE. Communication with treatment and child welfare staff is a critical element of success in the outreach role. Outreach workers need the support of child welfare workers, particularly in the initial engagement process. It is important to have the child welfare worker first introduce the concept of Project SAFE to clients and inform them of the outreach worker's visit. In addition, the first engagement home visit has a far more powerful impact in the client's life if the case worker is present.

### 3.4 The Engagement Role of Outreach

Outreach workers continue to play a crucial role in motivating clients to seek treatment services and in re-motivating clients who have prematurely disengaged from treatment activities. To understand the importance of this aggressive effort toward engagement, it is first necessary to understand the complex web of obstacles that often blocks client engagement in treatment and completion of the treatment process.

#### Obstacles to Engagement

The obstacles that serve to inhibit treatment involvement for Project SAFE clients are highly consistent with those noted in the literature review in Appendix A. The most

significant of these, and ways in which they have been addressed through outreach, are summarized below.

**Social Stigma:** The twin stigmas of child neglect and substance abuse have been extremely difficult for Project SAFE clients to confront. Exposure to recovering women through Project SAFE has done much to overcome this obstacle. The outreach worker has often played an important role in healing this stigma and instilling within the clients hope for future health and happiness.

**Denial, Distrust, and Hostility:** Many of the Project SAFE clients initially approach the project with adamant denial that they have a problem and intense resistance, if not outright hostility, toward the project. Distrust is clearly evident, as the treatment center is often viewed simply as an extension of DCFS and the courts. Client resistance is among the top five obstacles to client engagement cited by treatment staff in the 2001 Project SAFE survey. A number of factors have helped diminish these attitudinal barriers, including the persistence and relationship-building skills of the outreach workers. Their efforts have simply worn down some of the distrust and resistance.

**Enabling/Sabotage by Families or Significant Others:** Family and significant others in a client's social network do not always play supportive roles in the client's treatment and recovery process. Even well meaning family members may prevent treatment engagement by protecting potential clients from the consequences of their drinking or drug use. Multi-generational cycles of addiction are also becoming more prevalent in many SAFE sites. In their descriptions of their last five clients (in the 2001 Project SAFE survey), the sites reported that 50 percent of those clients live with addiction in the household or in an intimate relationship. Some

family members and friends continue their enabling roles by affirming common myths about alcoholism, e.g., "You can't be an alcoholic; you only drink beer"; by affirming the client's natural hostility toward helpers; and by performing acts of sabotage to disrupt treatment, e.g., bringing over beer with the taunting adage, "My gosh, one won't hurt you." The lack of understanding by family members – or their attempts to discourage the client from receiving treatment – is listed in the 2001 Project SAFE survey among the top five obstacles to client engagement. And many clients' recurring relationships with drug-involved significant others jeopardize their completion of treatment and achievement of stability in recovery. "Significant other" was also listed in the 2001 survey as one of the top five obstacles to client engagement.

**Transportation:** Local DCFS offices and the local treatment agencies participating in Project SAFE cover a large geographical catchment area, encompassing not only central cities but also many widely dispersed small towns and rural areas. Transportation has been a major obstacle for many clients referred to Project SAFE. The challenges are most severe in the larger rural areas, where no public transportation is available and clients may live 50-80 miles apart. Outreach workers have taken responsibility either for assisting the client in finding transportation resources or for providing needed transportation to and from the treatment agency and self-help meetings. Outreach workers in some sites regularly provide transportation to and from treatment. Other strategies have included providing bus passes to clients so that they can make their way to treatment, organizing client car pools, or tapping other local health and human service transportation services.

**Child Care:** For women whose children are still in their own custody, "Who will take care of my children when I'm gone?" is a question

that must be addressed before they are formally enrolled in treatment. Child care issues represent the category of engagement obstacle most often cited as significant by Project SAFE staff. The outreach worker, child welfare caseworker, and primary counselor have all played a part in helping the mother explore the possible child care alternatives that might allow program participation. Project SAFE has built in funds to purchase day care services if no other alternatives are possible. Some larger sites have child care services on site as part of their regular programming. Others make referrals. During the project's early years the funds allocated within the project for child care services were not fully utilized, primarily due to the difficulty of finding appropriate child care services in the rural localities. In some cases, however, even though resources are available, prospective clients will use their child-care needs as an excuse not to enter treatment.

**Housing:** As soon as Project SAFE moved into major urban centers of Illinois, housing emerged as a major obstacle to clients' entering or successfully completing treatment. Homelessness and the need for safe, sober housing continues to be one of the most difficult challenges noted by SAFE staff from all regions, and listed among the top five obstacles to client engagement in the 2001 Project SAFE survey. In the survey portion that requested descriptions of their last five clients, the sites reported that 64 percent of those clients' living arrangements posed barriers to their recovery. Staff members in the focus groups described women living in abandoned houses, or in their cars, or moving from house to house as the families are evicted. Many clients have had housing/homelessness crises during their involvement with SAFE. Others have had housing, but housing that is not conducive to recovery, e.g., in a drug-saturated neighborhood or housing project. Recovery

homes for women are nonexistent or in short supply in some areas; and halfway houses, if they do exist and accept women, are often beyond clients' financial means. For women whose children are still in their custody, the presence of children or the ages of their children may rule them out for inclusion in the housing that exists. Clients who need residential treatment may not be able to enter treatment for fear of losing their housing. Outreach workers and treatment staff have spent considerable amounts of time dealing with basic issues of shelter and safety. The importance of addressing such basic safety and survival issues was captured in the words of a client who stalked out of a treatment center, saying, "What am I getting sober for? I don't even have a place for me and my babies to live."

**Medical Issues:** In the early 1990s, when the drug choice of Project SAFE women shifted from alcohol to cocaine, the number and intensity of reported medical problems of both the mothers and their children dramatically increased. In both urban inner-city and rural Project SAFE sites, significant staff resources were expended trying to access basic health care services for Project SAFE mothers and their children. In the past few years the drug of choice has shifted once again in some locations, often toward methamphetamines in the more rural sites, and toward opiates in the Chicago area. Medical care continues to be a significant issue, often exacerbated by the effects of child custody on Medicaid eligibility. Asked in the 2001 survey to describe their last five clients, the SAFE sites reported that 31 percent of those clients had co-occurring medical problems.

**Legal Issues:** Increasingly, prospective Project SAFE clients are involved in legal issues beyond matters of child custody. The need to make court appearances, and anxiety over such prospects, can complicate the

engagement process and conflict with treatment schedules. The prospect of serving time can make some women reluctant to invest their time and effort in treatment. Outreach workers and other staff in some SAFE sites have made it part of their routines to attend court appearances with clients, offering emotional support, helping them understand the legal process, and serving as a tangible sign of the treatment presence in these women's lives.

**Welfare-to-Work:** Increasing numbers of current and prospective Project SAFE clients are reaching the end of their benefits under Temporary Assistance to Needy Families (TANF). For women with little or no financial resources, the pressure to find jobs can be enormous, in many cases stronger than the pressure to enter or remain in treatment. An important part of the engagement process is often helping clients cope with their financial fears, find ways of making ends meet, and balance treatment and work schedules.

**Psychological and Psychiatric Issues:** Psychological issues noted by SAFE staff include lifelong patterns of mistrust, increasingly strong anger issues, and ambivalence about treatment. Asked in the 2001 survey to describe their last five clients, the SAFE sites reported that 38 percent of those clients had co-occurring psychiatric problems. Often the prospect of leaving the addictive lifestyle can be very frightening. All the skills epitomized in the outreach worker are needed to address these and other psychological issues. Mental disorders also stand as obstacles to engagement. For example, depression can make it very difficult for clients even to leave their beds, much less go to a strange location to learn to live without their traditional source of relief from their pain. Outreach workers must use their motivational powers to help clients overcome some significant barriers.

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In the 2001 Project SAFE survey, the sites were asked to name the three most important obstacles to the engagement of women who are appropriate for Project SAFE. Their answers, including the frequency with which each answer was given, are detailed below (if no number is given, the answer appeared only once):

- Child care = 8
- Client resistance = 4
- Significant Other = 4
- Homelessness—no real address 4
- Family member not understanding or discouraging need for treatment =4
- No phone or alternate contact =3
- No Shows =3
- Child welfare caseworker =3
- Employment =4
- Anger =2
- Denial =2
- Fear
- Wrong address
- Length of time between investigations caseworkers handoffs
- high risk neighborhood
- Manipulation of system: PT perspective as well as systemic inadequacy
- fear of signing children over temporarily
- Number of cases – not enough consistent communication – phone tag
- Reluctance to stop usage because they enjoy the lifestyle too much
- Domestic Violence
- Unable to serve clients in the outlying counties
- If needing residential treatment waiting lists
- Environmental/community dysfunction,
- inadequate resources
- Transportation
- Prioritizing other responsibilities TANF etc.
- Shot records for children to go to daycare not up to date

- Feelings of being overwhelmed with all of the changes needed to have recovery
- Arrest
- Psychiatric and medical issues
- DCFS/POS referral
- Clients maintaining sobriety
- Transportation
- Auxiliary Appointments
- Referrals
- Assessment and Physical process
- Ability to locate potential patients
- Boundary lines
- Financial

### **The Outreach Role in Engagement**

There is a period of incubation that breaches the span between active addiction and emotional investment in a treatment process. While treatment is usually thought to begin with the client's formal admission to treatment, outreach workers in Project SAFE have actually played a critical role in initiating this incubation or engagement process and pushing it to a successful outcome. outreach services modeled after those in Project SAFE warrant placement as a treatment modality in the continuum of substance abuse services. outreach services begin the change process by:

- creating hope,
- removing environmental obstacles to recovery, and
- confronting chronic patterns of self-defeating behavior.

As part of the outreach process, change has already occurred to empower the client to enter formal treatment. Without outreach worker involvement in nurturing this incubation process, many Project SAFE success stories would never have entered treatment.

The first stage in the incubation process is the building of relationships with actively addicted women. To build these relationships, outreach

workers, through their patience and tenacious effort, have had to transcend their discomfort in the face of open hostility. The earliest stage of this relationship is marked by distrust and paranoia, testing, attempted manipulations, and attempts to destroy the relationship. The most critical role of the outreach worker during this stage is embodied in her consistent physical and emotional presence, her willingness to listen non-judgmentally, and her ability to provide some concrete service, e.g., transportation. The initial client position is often: "Who are you, and what do you want from me?"

Once the relationship has been established and survived the testing period, outreach workers increase their empowering messages ("You can change your life") and look for opportunities to move the woman emotionally and physically closer to entry into treatment. The outreach worker's ability to be present in the life of the client during periods of crisis is particularly important. One outreach worker eloquently expressed this role: "You must be there when they hit bottom. You must build a relationship, so that in crisis they reach for you and not the drug. Hitting bottom doesn't necessarily mean change. When she hits the bottom alone, she reaches for the drug and addiction continues. When she hits the bottom and I'm there (representing hope), change is possible!"

For many women (and men) the earliest stage of treatment is not "surrender" or "acceptance" or admission of "powerlessness," but an active, at times aggressive, display of ambivalence regarding both addiction and the desirability or possibility of sobriety. Outreach work places a positive force in the psychological and social arena within which this ambivalence is decided. The exploration and fragile resolution of this ambivalence, the tentative emergence of hope, and the resolution of fear related to the physical and psychological safety of the

treatment milieu are all precursors to formal entry into treatment. Treatment begins, not with formal entry into Project SAFE's intensive outpatient modality, but with the exploration of these issues during the outreach process. A crucial dimension of outreach services is their ability to engender treatment readiness and receptivity among previously treatment-refusing and treatment-resistant clients. **This is an emerging modality that has the power to reach previously unreachable people with addictions!**

Outreach workers in Project SAFE have described a number of essential dimensions of the outreach engagement process. In their own words, those dimensions are:

- **Expecting Resistance:**
  - "Resistance is to be expected; we should be shocked when it's not there and suspicious that we're getting hustled. These women initially see us as an extension of the agency that's taking their children and forcing them to get help they don't need or want. It takes time to work through their anger and distrust."
- **Respect on the Initial Visits:**
  - "I try to remember that I'm on her turf, that I'm her guest and that I remain there only with her permission. I want to minimize my power and let her feel we're on the same level."
  - "I try to empathize with her sense of being invaded, her feeling that all these strangers are getting in her business."
- **Capacity to Listen:**
  - "They can't hear you until you've heard them. The trick is to shut up and listen until they are ready to hear what you have to offer."
  - "I think it's the first time they've been listened to and not judged."
- **Self-disclosure:**
  - "I wait for the right time and then I share my story and my gratitude about

- what happened to me as a result of treatment.”
- **Identification:**
    - “I listen to her story and then I tell her mine. When she figures out I been where she's at, something just seems to click. It's like they want something I got and for the first time figured out it might be possible to get it.”
  - **Empowerment:**
    - “It's harder for the women I see in the projects because they don't see a lot of people making it. I hope she can identify with me in a way that opens up her sense of possibilities and choices.”
  - **Affirmation:**
    - “I tell her something good about herself—something I see that others may have missed.”
    - “I just keep listening and telling her everything's possible until she asks me, ‘How?’ Then I tell her that her beauty's being wasted and what she can do for herself and her family.”
    - “I just kept leaving those ‘You can do it!’ notes on her door.”
    - “I affirm her hope of getting her kids back. I tell her I think she's strong enough to do what it takes to get them back.”
    - “I believe in you.”
  - **Refusal to be Rebuffed:**
    - “You've got to let them get all their anger out before they can hear anything you've got to say. When they're done cussing, I start talking.”
    - Said through a closed door: “I know you're there. I know you're mad. But I ain't gonna give up on you. I'll be back tomorrow. I hope you have a good day.”
    - “At first she didn't want to talk to me, but I just kept showing up at all her court hearings.”
  - **Tenacity:**
    - “They have to know you care enough that you won't give up.”
    - “They've got to know you'll keep coming back. When they figure that out, they relax and deal with you.”
    - “She's not here? Tell her I will be back many times.”
  - “You don't think you're going to like me? I'm not sure I'm gonna like you either. So what are we going to do here?”
  - **Reducing Fear:**
    - “I told her it wasn't scary—that it was like a club of women like her, that she would know people there.”
    - “I'm like their personal coach. I describe what it will be like and tell them I will be there with them every day.”
  - **Aggressive Problem Solving:**
    - “My job every day is to resolve anything that threatens to keep this woman from getting to Project SAFE.”
    - “I tell her this program is designed for her—that we have things other programs never had: transportation, day care, people who know how to counsel women.”
  - **Reality Therapy:**
    - “Who am I? I'm somebody who can show you how to get those people off your ass!”
- ### 3.5 Selection and Support of Outreach Workers
- #### Selection of Outreach Workers
- The ability to fulfill all these difficult functions requires a very special human being. Often treatment staff with more education, more impressive credentials, and higher salaries remain in awe of the outreach workers. SAFE staff who recruit and hire outreach workers look for a number of components:
- Street experience
  - An ability to understand how clients think
  - An ability to relate to clients on personal and professional levels simultaneously
  - Empathy for clients, whether or not the outreach worker has a history of addiction and recovery

- A knowledge of recovery groups, including which groups are safe, which groups are not safe, what can help clients, and what can hurt them

Some of the strongest inspirations for clients, and proof of the power of recovery, are the outreach workers who began as Project SAFE clients. One focus group participant noted that, in spite of her coming from a mental health background in which she would not have considered hiring a former client, she had found that with the outreach role it was possible to do so without breaching any ethical boundaries.

Our discussion of the qualities sought in the selection of outreach workers would not be complete without a profile that was developed during the project's early years and still holds true:

- The ideal outreach worker for Project SAFE is a woman who both understands and is deeply committed to the project. She brings to her role a rich and varied life experience that has bred a deep well of understanding, tolerance and common sense.
- Substance abuse has touched her life through her own addiction and recovery (at least one year) or through the experiences of someone close to her.
- She may be older than most of the women she works with, who may at times view her as an older sister or the understanding mother they never had.
- She is drug-free and is, in fact, a walking message that one can live, lose, learn, laugh and love, all without alcohol or drugs. She knows a lot of people who are recovering and is, for the women with whom she works, a human link to relationships and activities grounded in sobriety rather than intoxication.
- She is as comfortable (perhaps more so) talking and listening in a messy living

room or in a car as in the formal office setting that some of her clients would experience as alien.

- She is persistent and tenacious, seeing resistance and even hostility as defenses that hide disease. Her compassion always helps her look beyond the external presentations of the disease to see the person within.
- She knows when to share her own experiences and when to be silent. She knows the healing power of laughter.
- She can reach out without rescuing, be empathic without enabling, and be honest without being hurtful. She can nurture and love, but hers is a tough and truthful love.

### **Support for Outreach Workers**

The outreach worker role in Project SAFE has brought with it stressors somewhat different from those usually experienced by child welfare and substance abuse treatment staff. The outreach worker role often involves extensive travel, sustaining contact with clients geographically dispersed over large urban and rural catchment areas. In-home time with clients places outreach workers in physical environments that are at first unknown, at times less than comfortable, and sometimes unsafe. At project inception the outreach worker role was by design less structured than other roles. While this structure has evolved in response to experience with project clients, the role ambiguity that is part of this process has not been without its stressful periods.

Clearly the most stressful and rewarding aspect of outreach work with Project SAFE is the emotional relationship between outreach workers and project clients. It is the very intensity of these relationships that makes the outreach worker so essential to the project's success, and yet this very intensity has tested the emotional vulnerability of each worker.

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The normal process of self-support for the outreach workers has also been strained in some cases by their roles in the project. Outreach workers who are recovering from their own addiction or co-dependence have found themselves, at times, experiencing some role confusion and role conflict in their participation in their own self-help groups, e.g., Alcoholics Anonymous or Al-Anon. The presence of Project SAFE clients at these meetings finds the outreach workers wearing two hats simultaneously. They are in a professional helper role with the clients, and yet they are at the meetings to address their own emotional needs.

Another challenge for outreach workers in recovery has arisen as the range of addiction self-help options has expanded beyond the realm of the 12-Step programs such as A.A., N.A, and C.A., encompassing a variety of recovery groups (e.g., Women for Sobriety, non-spiritual groups like Secular Organizations for Sobriety or Rational Recovery, and faith-based and church-based groups). In some groups that clients choose to attend, the understanding of addiction and approaches toward recovery may be very different from or contradictory to those espoused in treatment or the self-help structures in which the outreach workers have recovered. The outreach worker may experience internal conflict in fulfilling her duty to honor the client's choice of recovery support systems.

If the unique stressors of the outreach worker's role are not appropriately managed, both the quality of client services and the personal recovery and health of the outreach worker can be compromised. The following thoughts and strategies are offered related to special measures that can support the health and productivity of outreach workers involved in Project SAFE and similar projects.

- Experience in Project SAFE suggests that recovering people should have a stable period of sustained sobriety (at least one year, and preferably more) before assuming an outreach worker position.
- Given that many outreach workers will not have had previous professional experience, consistent and supportive supervisory contact is essential.
- Outreach worker supervisors must have some experiential "feel" for the clients and social terrain of Project SAFE. Periodic excursions with outreach workers in the field are encouraged for supervisory staff.
- One element in the supervision of outreach workers involves identifying and resolving issues of counter-transference. Given the intense emotional involvement required of the outreach workers, there are inevitably times when the outreach workers' own emotional/ developmental issues can interfere with effective service delivery. Regular support and supervision can help identify and prevent such issues from spilling into the outreach worker-client relationship. The hardest lesson to remember, as self-reported by Project SAFE outreach workers, was that "The client cannot recover exactly the same way as the outreach worker recovered."
- Supervision of recovering staff must include exploration of this "two-hat" issue. Both supervisors and outreach workers are encouraged to read and discuss the following publications: "A.A. Guidelines for A.A. Members Employed in the Alcoholism Field," distributed by the General Service Office of Alcoholics Anonymous; and "Working As, For and With Professionals," distributed by the Al-Anon Family Group Headquarters.
- Project SAFE outreach workers have expressed unanimous belief in the importance of separating personal recovery from one's job, e.g., attending A.A. meetings not attended by clients.

- Both child welfare agencies and treatment agencies must avoid contributing to this two-hat conflict by placing the outreach worker in untenable positions. The outreach worker is not paid to go to A.A. meetings, represent A.A., speak for A.A., or negotiate with A.A. Most important, the outreach worker is not a spy whose purpose is to disclose to outsiders the nature and intensity of client participation in A.A. Anonymity of A.A. members and the confidentiality of the A.A. meeting must not be violated.
- For outreach workers in recovery, supervisors should be cognizant of any conflicts the outreach workers might be experiencing in their work with clients who have chosen recovery paths that are markedly different from their own, and help the outreach workers to work through those conflicts.
- Group supervision of outreach workers, or at least some structured opportunities for outreach workers to come together for sharing and support, is extremely beneficial. Such opportunities not only sharpen technical skills and approaches, but also allow workers to both clarify their roles and offer mutual support.

In 1997 OASA published *The Delivery and Supervision of outreach Services, Project Safe*, developed by Chestnut Health Systems/Lighthouse Institute. The purpose of this manual was two-fold: to serve as a source of training and support for outreach workers and their supervisors, and to capture the knowledge base that was being developed through the evolution of the outreach role in Project SAFE. *The Delivery and Supervision of outreach Services* is being used regularly as a training tool for new outreach workers at Project SAFE sites. It addresses many aspects of the outreach role, including characteristics of Project SAFE clients, challenges in becoming an outreach worker, the many

outreach worker functions, issues in service delivery, and professional development issues.

### 3.6 Current and Ongoing Issues in Outreach

Outreach is largely a hybrid role that has sprung up in response to multiple challenges in serving a troubled population. The issues that have surfaced regarding this role have more to do with the preservation and protection of the outreach workers themselves than with the effectiveness of their work. Three issues will be explored, concerning the safety of outreach workers, the development of outreach workers, and preservation of the outreach role.

#### Outreach Worker Safety

The physical safety of outreach workers has been an issue of concern across the Project SAFE sites since the mid-1990s. Shootings and other forms of violence have increased in many of the areas in which Project SAFE clients live. The proliferation of crack houses and other drug houses has made some forays into clients' environments particularly dangerous. In the 2001 survey, two sites reported that at least one of their outreach workers had experienced a major threat to their safety in the past year while performing their outreach duties.

Concerns over the physical safety of outreach workers have precipitated the development of several specialized procedures, including:

- increasing training related to physical safety issues and aggression management;
- signaling, at the time of DCFS referral, environments that may be of particularly high risk;
- conducting in-home staffings with DCFS in cases of extreme danger;
- using the outreach workers' instincts and common sense to identify and avoid dangerous situations;

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- designating some sites in which outreach workers will not pick up clients;
- canceling or rescheduling a visit if the danger signals seem particularly pronounced;
- the increasing use of teaming by outreach workers, particularly on initial visits;
- maintaining a list at the treatment site of every location outreach workers are scheduled to visit;
- restricting some home visits to certain hours of the day; and
- using paging and call-in systems to maintain closer communication between the outreach worker and the treatment site supervisor. (Several sites now provide portable cellular phones, pagers, and/or walkie-talkies to outreach workers).

In some sites the introduction of these safety measures has been slow in coming because of budgetary problems. Reliable transportation is another safety factor. At one site there is only one outreach worker, and the site does not have a van. The need to have two workers, rather than one, involved in home visits has decreased the number of home visits that can be made in some locations. In sites that have only one outreach worker, a team approach is impossible, and the outreach worker may simply take the risk.

In the public housing projects in Chicago, gangs often have complete control over the terrain, dictating who may come and go and enforcing that rule with violence. As the projects have been dismantled over the past few years and clients have been relocated, that problem has dissipated considerably. However, staff of one Chicago site spoke of the creative solutions that outreach workers and clients developed when the projects were still in operation, including approaching gang leaders, explaining the purpose of their visits and the reason clients were leaving to go to

Project SAFE, and negotiating safe passage for clients and outreach workers.

### **Development of Outreach Workers**

As outreach work has emerged as a highly valued and increasingly professionalized area of service activity with Project SAFE, concerns have been raised about the career ladder for outreach workers. While discussions have pointed out the need for more adequate salaries and career advancement opportunities, no formal, collective response to this need has occurred across the SAFE sites. The need for such a response may be indicated by the higher rate of turnover among Project SAFE outreach workers at some sites. It is unclear the extent to which this turnover is related to increased career opportunities (offering relief from the traditionally low pay-scales for outreach work) or to discomfort with the working conditions within the outreach role.

It would be interesting to compare the different factors that influence high and low retention rates in the outreach worker roles across the 23 service sites. Some sites turn over outreach worker positions each year, while a few sites still have their original outreach workers. In the 2001 focus group discussions, the highest rates of position stability were reported in the Central Illinois and Cook County regions. The lowest salary rates were reported in the Southern Illinois regions, while in some Cook County sites, outreach workers are paid more than or the same as clinical staff. Some sites with lower outreach salary levels try to compensate with strong benefits programs.

Participants in the evaluation meetings have called for a "professionalization" (in the best sense of this term) of the role of outreach through:

- the development of preparatory training programs,

- access to continuing education benefits,
- the creation of adequate salary structures, and
- the conscious development of career paths/ladders for outreach workers within the agencies in which they work.

Some Project SAFE sites reported that they make ongoing training opportunities available for outreach workers, and a few sites have outreach workers with clinical credentials and have moved those workers toward a more professionalized outreach role, including formal case management responsibilities. The stress and unique qualities of the outreach role also tend to create a strong need for greater sharing of information and support among outreach workers from multiple sites. Focus group participants were unanimous on the need for gatherings of outreach workers, either in the form of a statewide outreach meeting or a separate track at the annual OASA/DCFS Initiative, or in smaller groups held more frequently on a regional basis.

### **Preservation of the Outreach Role**

This issue is the sum total of all the other issues, in a field in which the presence of outreach is the exception rather than the rule. This role that has proved so pivotal to the success of Project SAFE may be considered a luxury by many less familiar with the project, in a fiscal environment that often prohibits luxury. Although the SAFE site contracts mandate the presence of at least one outreach worker, the hybrid nature of the outreach role makes it tempting to eliminate the role and divide its duties among other staff. The sheer overload on outreach workers who try to perform all of the duties ascribed to that role also necessitates the shedding of some duties. And yet experience has indicated that it is the very hybrid nature of this role that has generated its success. Which combination of duties has led to that success? Or is it not even

a combination of duties, but rather the unique nature of the outreach worker that has worked its magic in the lives of so many women and families? And as the outreach role evolves, how will the outreach workers themselves evolve? A detailed study of the outreach role, its strengths, its evolution in Project SAFE, and its points of vulnerability, would contribute greatly to the literature of the field as a whole.

The outreach role has been replicated in other DCFS collaborative programs (e.g., Drug Free Families With a Future and non-SAFE OASA/DCFS Initiative sites) and watched with interest by child welfare organizations across the country. Project SAFE has received and responded to requests for copies of *The Delivery and Supervision of Outreach Services* by a number of other states, including Minnesota, Massachusetts, and New York. The future of the outreach role has significant implications, not only for the success of Project SAFE, but also for the success of programs nationwide.

### **3.7 Recommendations and Best Practices**

While it is clear to all in Project SAFE that outreach constitutes a best practice in and of itself, the experiences of Project SAFE sites have pointed to a few large and small practices that might be considered elements of the most effective outreach work. They include:

- An aggressive outreach approach, characterized by:
  - multiple points of involvement in clients' lives; and
  - patience, persistence, tough love, and the many other qualities that have emerged in Project SAFE outreach workers.
- The appropriate assignment of case-management and clinical outreach functions to outreach workers, characterized by:

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- having outreach workers maintain close communication with all players in the client’s treatment, including counseling, IOP, and case management;
- consistent, regular collaboration between outreach and child welfare workers, with daily contact, wherever it is necessary; and
- having outreach continue its follow up and case management role after treatment is complete.
- **Continued outreach involvement in the engagement process, including:**
  - joint home visits by child welfare and outreach workers when a client is being introduced to the project;
  - in-home pretreatment sessions, before intake, conducted by outreach workers, include formal obstacle-assessment processes, so all obstacles can be identified resolved before treatment begins; and
  - having the outreach worker present when the client first arrives at treatment.
- Careful and comprehensive safety measures, including:
  - adequate training in safety and aggression management;
  - sending outreach workers out in pairs, particularly for the first visit;
  - providing cell phones, pagers, and/or walkie-talkies, particularly in dangerous areas;
  - scheduling an in-home staffing with DCFS if the outreach workers perceive danger; and
  - having a van in good working order.
- The use of outreach to prevent the loss of client involvement during transitions in the program, including:
  - stepping up outreach services a few weeks before and during continuing care or aftercare, to keep client engagement high and avoid relapse or attrition; and
- having outreach maintain contact with women during and after the transition to the next level of service, and after graduation, letting outreach escort the woman to the next level of service, if need be.
- Careful attention to the development and management of outreach workers and the outreach worker role, including:
  - a statewide study and analysis of outreach work and outreach workers, to determine the best directions for future development of the outreach function;
  - strong support for outreach workers that effectively addresses the stress factors unique to their role;
  - beginning with training for outreach workers until they are comfortable with their knowledge of the job, then sending them out with more seasoned outreach workers for on-the-job mentoring;
  - using *The Delivery and Supervision of outreach Services* to train outreach workers and sending outreach workers to as many additional trainings as possible;
  - active management of outreach , to maintain an aggressive approach toward their function;
  - holding regular meetings of outreach workers, within a particular treatment network or region, or within the state as a whole, so they can share problems and solutions;
  - setting salaries for outreach workers that match the value of their work and give them incentive to remain in outreach positions; and
  - looking at staffing patterns and making sure that adequate outreach time is allotted to the functions that provide the greatest effects.



## Chapter Four:

### Treatment Services

This chapter reviews the evolving demographic and clinical characteristics of Project SAFE clients, describes the design of the treatment protocol used within Project SAFE, and discusses the pathways and styles of recovery exhibited by Project SAFE clients. The chapter also identifies some of the best practices across the twenty-three Project SAFE sites in Illinois, and discusses some of the critical concepts upon which these practices are based. The more child- and family-oriented services are described in Chapter Five.

#### 4.1 Characteristics of Clients

The treatment design utilized within Project SAFE has been in almost constant evolution since its inception in 1986. One of the major influences pushing this evolution is the changing characteristics of clients entering the SAFE programs. Some of the more clinically significant of such changes among the 22,272 women admitted to Project SAFE in FY 2002 include the following:

##### *Age*

There are three populations of Project SAFE clients: young women with a short history of cannabis use; young heroin, cocaine, or methamphetamine addicted women entering treatment before their twenty-first birthday; and a group of women aged 22 to 45 years for whom the use of heroin, cocaine, alcohol and other drugs has become a pervasive and enduring lifestyle. Some members of the third group were referred to Project SAFE in earlier years, but either refused treatment, did not complete treatment, or completed treatment but later relapsed and returned to compulsive drug use. The average age of Project SAFE clients has increased from 28 years of age in FY 1990 to 32 years of age in FY 2002. The

age of clients most recently admitted to Project SAFE varies considerably across sites, with the average client admitted to Rock Island being 27 and the average client admitted to one of the Chicago sites being 35.

The widening age span and varied level of drug involvement of Project SAFE clients create case mix problems that must be actively managed.

*We have clients who are younger, 17-19, with problems related to their marijuana use who are hard to engage in treatment. They might get started in treatment, then decide to relinquish responsibility for the baby to a relative. Or they don't even try. They just say, "I'm not like you." When they're so young, it's hard to get them to accept that they have a problem, particularly when they see the really bad addictions of the older women. Its hard to mix these younger clients with our older women. We're also concerned about the effect some of the older women could have on the younger, more naive women.*

##### *Ethnicity*

The percentage of minority families served by Project SAFE varies considerably across the sites. While African-American women make up the largest percentage of admissions, their representation ranges from as high as 100% in some of the urban sites (e.g., CMHC of St. Clair County) to as low as 8% in the most rural site (Franklin-Williamson Human Service). The overall racial composition of clients admitted to Project SAFE in FY 2002 was:

Black/African-American	55.9%
White/Caucasian	33.9%
Mexican	4.4%

Puerto Rican	3.7%
American Indian.	7.0%
Hispanic Other	.7%
Cuban	.08%
Asian	.08%
Other	.5%
Alaskan Native	.04%

The racial composition of Project SAFE clients has changed markedly since the original piloting in 1986-1988. The percentage of African-American clients rose from 21% in 1986-1988 to more than 50% as Project SAFE expanded from the pilot sites in north-central and north-western Illinois to urban communities throughout Illinois.

### ***Marital Status***

The marital status of FY 2002 Project SAFE clients is summarized below.

Never Married	61.0%
Married	13.1%
Divorced	10.6%
Separated	8.6%
Widowed	2.2%
Unknown	4.5%

The majority of women entering Project SAFE are single, although most are involved in an on-going intimate relationship at the time of admission. The rural sites are more likely to have women who are married or divorced.

The intimate partners of Project SAFE clients figured largely in their treatment, both negatively and positively.

*I went to pick up a client 3 weeks ago, her first time in treatment. She got in the van, and here comes her husband. So he got in the van, saying "I'm coming with her." He was drunk.*

Some partners, particularly those also involved in substance use, seek to actively sabotage

treatment, while others constitute a significant source of support for the Project SAFE client's recovery. Some partners even use the SAFE client's entry into treatment as a stimulus to seek out treatment themselves.

As the women referred to Project SAFE arrive with more severe and more enduring substance use problems, they are also more likely to be married to or involved with men who are in the criminal justice system. The movement of these men back and forth from the community to correctional facilities has elevated the prison to the status of a significant institution in the lives of some Project SAFE families.

### ***Sexual Orientation***

The SAFE 93 evaluation report noted for the first time that clients were entering SAFE either self-identifying themselves as lesbian or bisexual or confused or conflicted about the issue of sexual orientation. This trend continued through the 1990s and into FY 2002.

Confusion about sexual orientation for some women entering SAFE is exacerbated by sexual victimization in childhood, by prior sexual experiences with women via prostitution, and by a general inability to define and assert boundaries in relationships with either sex. Treatment responses to these issues included more open discussions about sexuality and sexual orientation, monitoring the treatment milieu to prevent homophobic scapegoating of lesbian and bisexual clients, and responding to the disruptive effects of treatment romances between clients. Project SAFE staff report that the increased visibility of this issue reflects more the changing quality of the treatment environment (increased psychological safety) than it does changing the characteristics of clients.

### ***Children***

Women admitted to Project SAFE in FY 2002

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had an average of 2.3 children, but this number belies the enormous diversity of family size. The changing characteristics of families and children in Project SAGE will be discussed in detail in Chapter Five.

### **Education**

The educational level of FY 2002 Project SAFE clients has remained relatively constant with an average of 10.78 years (10.6 years average in FY 1990). What is significant in this data is the range in educational level across some of the Project SAFE sites. Clients at the LSSI site, for example averaged 7.09 years of education where those at the ProCare site averaged 11.89 years of education. Some of the sites note a lowering of the level of functioning of women entering SAFE.

*Our clients are very functionally illiterate. They can't write, can read very little, and have low cognitive abilities. Most have only gone through 8<sup>th</sup> grade, and very few have GEDs. Their attention spans are very short. We go over the DCFS goals with them, and when we ask them a question about them five minutes later, they don't understand. Even if they're not using, they don't understand.*

### **Employment**

The employment status of Project SAFE clients has changed considerably over the history of this Project. In the 1986-1988 pilot sites, only 12% of clients worked full or part time. Today that figure has more than doubled (24.43%), and, at some SAFE sites, more than 50% of clients admitted in FY 2002 were employed. This status requires greater flexibility in scheduling treatment services and allied support services.

*Our working mothers pose a significant challenge....saying they can't come to our morning programs because they're either working mornings or late the night before.*

*All the TANF issues have come up since the last SAFE evaluation. We have more women working and more women feeling the pressure to go to work. It is difficult to integrate all these service appointments and the concurrent demands of work.*

*It's often money. I need to go to work, my kids can't come home if I don't have a roof over their heads is the one I hear the most. A lot are forced because of welfare to work. Most don't get any kind of cash assistance anymore, they've long burned that bridge.*

Work schedules have necessitating transferring some Project SAFE clients from traditional, evening intensive outpatient services.

### **Pattern and Intensity of Drug Use**

The primary drug of choice of women entering Project SAFE has changed from alcohol (1986-1988) to alcohol (rural sites) and cocaine (urban sites), (1989-1995) to combinations of alcohol, cocaine, cannabis, heroin or methamphetamines (southern and western sites) (1996-2002). The major drugs of choice among women admitted to Project SAFE in FY 2002 were the following:

Alcohol	29%
Cocaine	18.6%
Crack	16.4%
Cannabis	17.3%
Heroin	10.3%
Methamphetamine/	3.9%
Other Stimulants	

Multiple drug use is the norm, with alcohol, cocaine, cannabis, and prescription psychoactive drugs often combined with other drugs. The Chicago sites noted the growing presence of PCP combined with other drugs and several sites noted that for the first time they are admitting women whose primary and sole drug choice is cannabis. The emergence

of methamphetamine as a primary drug choice represents a new trend, particularly within the rural service sites.

*Methamphetamine is a new drug of choice for our clients the last year and a half. I've been with the agency 4 years, and was with DOC before, and I've seen a dramatic increase in IV methamphetamine use in the last 6 months. We have 16 residential beds for women, and for the past 4 months, the house has been full of meth users.*

Project SAFE staff note that clients are bringing substance use histories of greater duration and intensity than in earlier years of the project. Clients are also presenting with more intense involvement in the addiction lifestyle and cultures of addiction. As one outreach worker noted, "I'm seeing more and more clients who are as addicted to the drug culture as they are to the drug." Such cultural enmeshment underscores the need for a focus on constructing sobriety-enhancing social supports and lifestyles for Project SAFE clients.

Another adaptation is being spurred within Project SAFE from the rising presence of heroin as a primary drug of choice. Several sites noted that they are seeing an increase in the number of women who are being maintained on, or who could benefit from, methadone. This has called for a greater understanding of methadone by all of the service constituents that are part of the Project SAFE collaboration.

### ***Sexual Abuse History***

Throughout Project SAFE's history, case workers, outreach workers and therapists have explored the clinical significance of, and appropriate service responses to, the sexual abuse so prevalent in the developmental histories of Project SAFE women. Four critical

observations summarize current thinking on these issues.

1. **Prevalence:** The prevalence of childhood sexual abuse and/or sexual trauma in the histories of Project SAFE clients has remained quite high over the past decade. The percentage of clients who self-report childhood sexual abuse during their treatment involvement ranges from 45-95% across the Project SAFE service sites in Illinois.
2. **Traumagenic Factors:** During the 1993 SAFE evaluation meetings a pattern of what came to be called "traumagenic factors" related to the sexual abuse episodes of Project SAFE clients was first identified. What these factors underscore is that it is not just the fact of sexual abuse that is significant in the lives of these women, but the intensity and duration of the trauma related to that abuse. Evaluation meetings over the past decade have further confirmed the existence of particular circumstances surrounding the abuse events which contribute to the trajectory of damage resulting from sexual abuse. The sexual abuse experienced by women admitted to Project SAFE tended to be characterized by the following circumstances:
  - early onset of sexual abuse (heightened physical and psychological vulnerability)
  - long duration of sexual abuse (most often measured in years)
  - perpetrators from within the family or with a close relationship to family (heightened violation of trust)
  - multiple sexual perpetrators
  - violence, or threat of violence, accompanying the sexual abuse (magnification of trauma)
  - more personally violating (boundary-invasive) forms of sexual abuse
  - not believed and not protected, or blamed and not protected when silence

- was broken about the sexual abuse (escalation of abuse following breaking silence).
3. PTSD: Clinical staff within the Project SAFE sites are increasingly viewing many SAFE clients as suffering from a pattern of Post Traumatic Stress Disorder (PTSD) related to their sexual victimization. In this view, substance abuse, depression and anxiety, a propensity for transient and toxic intimate relationships, addiction to chaos and crisis, and impaired parenting are all overt manifestations of, or responses to, PTSD. The treatment of addicted women within Project SAFE is increasingly being subsumed under a broader paradigm of the treatment of developmental trauma.
  4. Risk of SAFE Children for Sexual Abuse: There was an early recognition within Project SAFE that the children of SAFE clients were inordinately vulnerable for sexual victimization. The most frequent reason for referral of the children of women enrolled in Project SAFE for psychological or psychiatric services involves concerns related to the suspected or reported sexual abuse. Discussions indicating why these children might have been at higher risk for abuse than other children included the following points.
    - Some of the same perpetrators who abused SAFE women have access to their children.
    - The propensity of SAFE women to become involved with intimate partners with multiple-problems creates an "at risk" environment for their children.
    - There has been a slight increase in the number of SAFE clients who have themselves been involved in the sexual abuse of others.
    - Decreased supervision of children by drug using parents may increase the children's exposure to a broad spectrum of victimizing behaviors.
- Having rarely experienced boundaries of appropriateness and having not been protected, Project SAFE mothers may have difficulties teaching such boundaries and affording protection to their children.
  - The dependence of a drug-using woman on her paramour for drugs, money and shelter contributes to the denial that this same partner may be physically or sexually abusing her children.

#### ***Prior Treatment***

As a group, the women admitted to Project SAFE on average have less than one (.88) prior treatment for substance use. There is a considerably span in treatment history across sites, with some sites (ProCare) admitting mostly women with no prior treatment history and other sites (White Oaks) admitting women with 2 or more prior treatment admissions. Those sites that offer a wider range of services for women attract clients from a larger geographical range and attract more referrals of women who have prior histories of treatment. Overall, Project SAFE is continuing to reach a population of untreated chemically dependent women that would not likely be accessing treatment services for themselves or their families except through the auspices of this project.

Project SAFE is also serving a smaller group of women who have multiple past episodes of treatment and chronic problems of relapse. These women pose a special challenge to Project SAFE staff. A very difficult issue within SAFE is delineating those women whose internal and external obstacles to recovery require two or more treatment episodes before stable change can occur and those women whose personal and environmental deficits are so great and their resources so limited as to make initiation and maintenance of recovery an impossibility at this time.

Project SAFE sites are increasingly confronted with a unique dilemma: how to respond to clients that do exceptionally well once stabilized in treatment but are unable to sustain this level of functioning without regular participation in this structure. Such clients relapse and re-initiate contact with treatment to regain some semblance of safety, predictability and hope in their lives. This raises the question of the kind of long term support structures that may be required to sustain treatment gains achieved by women living within highly disorganized families and communities.

***Prior Psychiatric Treatment / Concurrent Psychiatric Illness***

Women entering Project SAFE have for many years presented with concurrent psychiatric disorders that complicated their treatment and on-going efforts at recovery.

*We are seeing a lot more dual diagnosis: increased reports of serious mental illness (major depression, bi-polar disorder, schizophrenia), including clients maintained on anti-psychotic medications, more anxiety disorders (panic disorders and PTSD), and more personality (borderline) disorders.*

Affective disorders and personality disorders are the most frequently noted concurrent psychiatric diagnoses of Project SAFE clients. Changes in co-morbidity issues during the past two years include an increase in clients experiencing severe depression, and an increase in clients with a history of schizophrenia. The number of women with histories of schizophrenia has increased over the past seven years. The number and intensity of these concurrent diagnoses affect both the type of adjunctive services needed (e.g, psychiatric consultation) and the duration of treatment required to achieve desired outcomes.

Women entering Project SAFE with personality disorders were generally presenting one of the Cluster B disorders: antisocial personality, narcissistic personality, borderline personality or histrionic personality. The traits and behaviors presented by SAFE women that were of greatest intensity and concern were immaturity, impulsivity, high risk-taking and sensation-seeking behavior, and exaggerated fears of abandonment. Phrases heard repeatedly to describe clients in the evaluation meetings included "harder to engage," "skilled at splitting staff," "attention-getting," "high need for excitement and drama," "more dissociation," "constant boundary-testing," and "involved with multiple agencies." As a result of these changes in client characteristics, Project SAFE sites have increased referrals to and collaboration with mental health agencies during recent years.

Other concurrent disorders presented by Project SAFE women included eating disorders and a small percentage of women who developed gambling problems during early recovery. Gambling problems seem to be restricted primarily to those communities in which riverboat gambling is available. Gambling as a substitute addiction is one that deserves some study, as Project SAFE staff note a parallel pattern of potential harm to children, e.g., scarce financial resources for the family once drained by drugs, later drained by gambling, improper supervision of children, etc.

Many SAFE clients with histories of psychiatric illness have experienced exclusion from mental health services.

*We also have problems with our local mental health provider in terms of dual diagnosis. They say "get rid of the substance abuse and we'll deal with the mental health issues," but the mental health issues interfere with their ability to get sober, and the women fall through the*

*cracks. The mental health intake process has been selectively getting rid of our clients.*

Many of the SAFE sites treat dually diagnosed women because of the lack of adequate referral alternatives. To support them in this effort, many of the Project SAFE sites are arranging for psychiatric consultation services provided from either within the agency or by another community resource. This has been one of the most important of the recently added components to Project SAFE.

### ***Aggression and Violence***

SAFE clients are at risk to be both victims of violence and perpetrators of violence. Prior SAFE reports have noted threats to the physical safety of SAFE women from community violence and domestic violence. Some SAFE clients depict a "war zone" environment in which they and their children sleep on the floor at night due to fear of drive-by shootings. Project SAFE women tend to be drawn from those communities that have been hardest hit by increased violence. Concerns about protecting clients and their children from community violence have had to be consciously considered in the design of service activities.

There is a recognition that many (63% at admission) women coming to Project SAFE are in relationships at high risk for violence, and that this risk may increase as a result of Project SAFE involvement. As Project SAFE clients change and become more assertive of their own needs and the needs of their children, partners often feel they are losing power and control in the relationship and may respond with violence. The same response can be triggered when women realize how destructive such relationships are and seek to extricate themselves. While threats of, or acts of, violence toward these clients are not new, several SAFE sites notes that violence-related

injuries to clients have become more severe during the past two years. At one evaluation meeting attended by representatives from three Project SAFE sites, those present could identify three former SAFE clients who had been killed in domestic violence incidents during the past year. Such tragedies underscore the need to link addiction treatment services for women with domestic violence resources. SAFE sites regularly refer women to domestic violence shelters, provide assistance in getting restraining orders, and provide relationship counseling to SAFE women. More sites are now involving local domestic violence programs in providing information and counseling services within the SAFE treatment regimen. Domestic violence shelters are increasingly being used to extricate women from violent relationships and violent neighborhoods.

Women entering Project SAFE in the recent years were themselves more likely to exhibit aggressive behavior than women referred in earlier years. Project SAFE staff observations on this issue include the following.

- More women than ever before entered treatment from social milieus in which violence was an approved method of achieving status and solving problems.
- Some of our women are involved with gang members or are themselves gang-affiliated. The potential for gang retaliation against the program and its staff is a real concern.
- Our women have been de-sensitized to violence. Deaths in their family and social worlds from homicide are not uncommon.
- We are seeing more women who are gang-involved and who routinely carry weapons.
- We're seeing ladies fighting ladies. I heard one of my clients yesterday saying "So-and-So didn't respect me; I had to cut her." Many of our ladies carry knives and talk of carrying guns.

- We have more women who have been assaulted by their paramours AND who have assaulted their paramours.
- There are more threats and physical confrontations among clients.
- We have had verbal threats to staff from clients.
- We discharged our first client ever due to a threat of violence.

Programmatic responses to increased risks of client aggression include both using an aggression risk assessment within the intake process and increased security procedures at some sites. Given the increasingly violent world from which clients are drawn into Project SAFE, it is crucial that the treatment environment be a sanctuary--a place of physical and psychological safety. Several Project SAFE sites use the presence of security guards at the facility to reinforce this theme of safety.

The issue of violence underscores an area of needed training within the project SAFE sites. Given the increased number of violent incidents involving clients or staff, staff training on critical incident debriefing of traumatic incidents would be quite valuable. This topic could be considered for an inclusion within a future Project SAFE conference, or held as a special centralized workshop for SAFE sites.

### ***System Sophistication***

Clients have been describe by staff during the past two years as much more "system sophisticated." Many of these clients are part of a culture of dependency in which they use helping institutions not to correct problems but to sustain them. These clients have chronic self-defeating styles of interacting with professional helpers and helping institutions that must be altered if fundamental change is to occur in their drug-using lifestyles.

Just one example of this culture of dependency involves how the clients manipulate the social security system to help sustain their drug use. Some mothers set their children up to qualify for SSI disability funds, thereby using "crazy checks" to support their drug use. Some clients also seek disability income for their substance abuse, funds which are all too often used to purchase cocaine. Some SAFE clients are in the midst of such manipulations at the time they enter SAFE. One of the most disruptive events in the recovery process occurs when a woman who previously applied for SSI disability suddenly gets a lump sum check ranging from \$4,000 to \$8,000 following final approval of her disability status. Involvement in such systems has been very disruptive to the treatment and recovery of SAFE women. As one outreach worker noted, "To place that much money in the hands of an addict in early recovery is to almost guarantee disaster." These stories reinforce the challenge of project SAFE, which is not simply to remove a drug from a client's life, but to remove the client from the cultures of addiction and cultures of dependency which nurture that person-drug relationship. In this context, the client's capacity for independence is continually being nurtured in Project SAFE.

*Our clients that are doing well seem to have found a way to break out of these cultures of dependency. That's why we are placing more and more emphasis on learning to read, getting a GED, going to college, and getting a job through which you can learn as well as earn.*

The treatment designs utilized within the Project SAFE sites have continued to evolve to meet the needs of individual clients and families who present with a greater number of problems, problems of longer duration, and fewer financial, social and psychological resources.

### ***Health Status***

Women entering Project SAFE are often experiencing acute medical problems. More women require detoxification and more sites find themselves in need of medical detox services. There have also been increases in the number of women presenting with tuberculosis, hepatitis and sexually transmitted diseases.

### ***HIV/AIDS***

Impulsive and high risk-taking behavior, substance impairment and involvement in drug-saturated social milieus all contribute to the risk of HIV/AIDS for women involved in Project SAFE. More women known to be HIV+ or to be diagnosed with AIDS are being treated in Project SAFE sites. While the number of clients known to be HIV+ remains small, the high incidence of other sexually transmitted diseases confirms client involvement in high risk sexual behavior across Project SAFE sites in Illinois. There were also increased reports of clients reporting IV drug use at admission. SAFE sites are intensifying their HIV/AIDS prevention and education efforts and linkages to HIV/AIDS case management and other HIV/AIDS services.

### ***Criminal Justice Involvement***

Clients entering Project SAFE in 2002 are more likely (currently 48%) than in earlier years to be involved in criminal enterprises to support their addiction. The most frequent types of criminal activities reported by clients include shoplifting, theft, forgery, and drug-selling. As a result of this criminal justice involvement, Project SAFE staff are having greater interaction with the courts.

### ***Unstable Housing and Homelessness***

There is more reported problems with housing than at any time in the history of Project SAFE.

*We're seeing women and families who are*

*truly homeless, because public housing rules have completely stiffened up. If the kid was in a fight, the family can't live there. A boyfriend shows up with a gun, they are kicked out. There's a substance abuse problem, they are kicked out.*

*In our local homeless shelter, everyone is using. When I take our women there, they end up out there using or prostituting.*

*We have SAFE women in continuing care who are living on the streets.*

What this has meant for Project SAFE is a closer collaboration with both residential treatment services and with recovery homes and greater advocacy for sober housing resources. Some sites have are also working with their public housing authority to create stable housing for clients during and following treatment.

### ***Relationships Between SAFE Clients***

One of the issues that arises with great frequency in Project SAFE is the pre-existing relationships between women referred to Project SAFE. There are numerous occasions in which two or more family members have been referred to SAFE within the same year. There have been three sisters, several mother and daughter pairs, and one family in which three generations of women (grandmother, daughter, and granddaughter) have been referred to the same Project SAFE site. Other pre-existing relationships shared by women entering SAFE include women who have children fathered by the same man, women who share the same biological father, women who were girlfriends and women who have used drugs together. These prior relationships constitute a potential source of disruption in the treatment process and pose greater risks for breaches of confidentiality in a group-oriented treatment modality. The sites have handled this in two ways. First, family members are

separated to the greatest extent possible either by placing them in different treatment programs or placing them in different groups and with different counselors. Confidentiality is enforced by emphasizing this value as a group rule and by encouraging women to use discretion in what they choose to discuss in group and in their one-on-one counseling sessions. In one site, a client's continuing breaches of confidential information shared by other clients in groups were so extreme and disruptive to the treatment milieu that the client was administratively discharged from treatment.

### ***Overall Level of Functioning***

Project SAFE staff and DCFS workers who participated in evaluation meetings over the past two years have consistently reported that women referred to Project SAFE were entering treatment with problems of greater intensity and duration. Clients as a whole are bringing in lower levels of intellectual functioning than in earlier years. Problems with literacy have become the rule rather than the exception. Clients also seemed to have a lower level of overall social functioning.

*Clients this year brought fewer personal skills and resources. They were more dependent—wanting us to do everything for them. Lacking skills and confidence, they were intimidated by any interaction with the world outside their family and the drug culture. Getting these women into the mainstream community is like introducing them to an alien world.*

*Clients are having a lot more trouble focusing in group. In treatment we're making it much more basic, because we can't hold their attention in the way we could even 5-6 years ago. We're dumbing down the program.*

This shift in client characteristics could reflect

changes in the total pool of women who abuse substances and who have histories of abuse or neglect of their children, or it could reflect a change in which women are being referred to Project SAFE from the local DCFS offices. When asked if they had a perception of which factor was responsible for the change, respondents from the treatment sites and DCFS responded that both were factors. DCFS workers felt that the decreased level of functioning noted in the meetings was endemic across their caseloads, but also reported that, with limited treatment resources available, they were referring those clients with the more severe problems and greatest need for treatment.

### ***Emergence of the Multiple Problem Client***

As a whole, Project SAFE clients share multiple problems that unfold concurrently or sequentially with a high propensity for intergenerational transmission. Each Project SAFE site was asked in early 2002 to profile five consecutive admissions. The multiplicity of problems is evident in aggregate data on 105 admissions collected across 21 sites: childhood sexual victimization (47%), criminal justice involvement (48%), co-occurring medical problems (31%), co-occurring psychiatric problems (38%), threat of domestic violence at admission (63%), and living with an addicted family member or intimate partner (50%). (Option: DO AS BAR GRAPH) Sixty-seven percent of the living arrangements of those admitted were judged to be a barrier to recovery.

In the 2001 meeting with Project SAFE sites, we heard the first reports of concurrent, three generational drug use (the SAFE client, her parents, and one or more of her adolescent or pre-adolescent children). Many of the women in Project SAFE presented complex service histories reflecting the challenges posed as they interacted with a categorically segregated service system. While these clients have

significant historical contact with social service agencies, the focus on one-problem-at-a-time and the essentially crisis orientation of these agencies has resulted in little changes in the quality of life and level of functioning of these women and their children. Project SAFE represents the beginning of a new generation of multi-agency, interdisciplinary intervention designs with increased capabilities of working with such clients.

Working with families experiencing multiple problems requires care in the management of client involvement in multiple service systems.

*Having too many demands and too much to do is a real problem for our women. I am constantly saying, “what do you have to do now? What can and can’t you handle? What can we prioritize?” We have to be careful that our clients don’t get so overwhelmed that they just give up.*

### **Breaking Intergenerational Cycles of Problem Transmission**

There is a growing awareness among those working within Project SAFE that this co-bundling of problems significantly increases the risks that the children of Project SAFE clients will sustain the momentum of these problems in their own lives. This potential is underscored by clients admitted to Project SAFE today who are the daughters or granddaughters of former Project SAFE clients. That awareness has given impetus to increased discussions about how to break what is being viewed as an intergenerational cycle of problem transmission. Those discussions have in turn led to many of the family- and child-oriented innovations described in Chapter Five. Project SAFE moved from a woman-centered model in its inception, to a dual-track woman- and child-focused model, to its current emergence as a family-centered model of care.

## **4.2 Treatment Design**

The addiction treatment services offered as a key element of Project SAFE are designed to:

- Assess the needs of the client and place the client in a level of care commensurate with the severity of her AOD and related problems.
- Continue the engagement and motivational enhancement process begun by the outreach worker.
- Detoxify and treat any residual alcohol-drug related medical problems experienced by the client.
- Resolve significant barriers to treatment participation and recovery.
- Disengage the client from the addictive lifestyle and begin the construction of a daily lifestyle conducive to personal recovery and family health.
- Enhance the client’s understanding of her problems.
- Increase the client’s skills and confidence in managing these problems.
- Help each client establish a sobriety-based support structure.
- Assist the client in the reconstruction of family roles, rules, rituals and relationships.
- Engage the client in an on-going culture of recovery through participation in aftercare counseling and mutual aid groups.

The service design chosen to achieve the above objectives is called intensive outpatient treatment. It blends the intensity of contact of residential treatment with the non-residential nature of traditional outpatient counseling. Clients do not live-in, but rather than the traditional one hour of counseling per week, treatment involvement ranges from 15-30 hours of service contact per week. The intensive outpatient treatment in the substance abuse field is perhaps most similar to what has been called day treatment or partial

hospitalization in the mental health field.

The original Project SAFE treatment design involved women from 3-5 hours a day, 4-5 days per week, for 4-6 weeks of active treatment followed by participation in aftercare and self-help groups. To accommodate the more intense patterns of addiction seen in recent years, the SAFE model moved to:

- three to six hours of treatment contact per day;
- 5 days per week plus self-help, treatment peer and outreach worker contacts over each weekend;
- 8-12 weeks of intensive outpatient treatment with a phased decrease in hours of daily contact; and
- sustained duration of contact (aftercare groups, individual counseling as needed and outreach worker contact) for up to one year.

In addition to the above, SAFE programs increased their utilization of residential treatment services prior to engagement with Project SAFE as a more intense initial stage of treatment for clients who could not initiate sustained sobriety early in outpatient treatment.

Each Project SAFE client is assigned a primary counselor to oversee the integration of assessment data into a comprehensive treatment plan and to implement and refine this treatment plan as new issues or problems arise. A number of activities are built into the basic designs of the Project SAFE intensive outpatient programs: individual, group and family counseling. All programs incorporated a lecture/discussion component within the daily schedule of treatment activities. This strong teaching component helps each client understand the addiction and recovery processes.

At some sites, Project SAFE clients are integrated into the existing intensive outpatient programs of the particular treatment site. Here the lectures and groups included men clients and women clients who are not in the SAFE project. However, at most Project SAFE sites women are involved in a gender-specific treatment track.

The group sessions which make up the heart of the intensive outpatient treatment provided through Project SAFE are designed:

- to build a milieu of trust within which emotional self-disclosure is possible and beneficial;
- enhance bonding and mutual social support between program participants;
- identify and remove self-defeating patterns of thinking and behaving that could sabotage treatment;
- diminish levels of denial, displacement, projection and anger and to enhance each client's willingness and ability to take responsibility for her own behavior;
- address concrete lifestyle changes that are integral to the recovery process; and
- provide a safe environment in which clients can develop and master skills to respond to critical incidents of early recovery (relapse prevention exercises).

Project SAFE has increased its service dose to respond to the number and intensity of the problems presented by the families it serves. Perhaps the other change in the Project SAFE model of 2002 compared to its earlier renditions is the greater degree of individualization of service plans. Project SAFE is today more a menu of services from which individual service plans are constructed than a structured program through which all clients proceed with the same sequenced elements of service.

## Treatment Issues

The full elucidation of all the clinical issues frequently encountered in the treatment of Project SAFE clients is beyond the scope of this report. It may, however, be important to at least identify some of these key issues so that clinicians involved in the replication of Project SAFE may have some ideas of the special needs of these clients.

Some of the most frequently confronted clinical issues with Project SAFE mothers include the following.

- Creating enough physical and psychological safety to facilitate dissipation of dysfunctional elements of the cognitive defense structure initially presented by the client *i.e.* denial, minimization, projection, anger.
- Overcoming historical problems with authority figures and general patterns of distrust that inhibit relationship building between staff and clients
- Overcoming low self-esteem and chronic patterns of self-defeating thoughts and behavior that inhibit commitment to the program by diminishing feelings of hope
- Responding to multiple problems (in some cases, day-to-day crises) that serve as diversions and distractions from treatment
- Responding to the onslaught of feelings that accompanied the emotional thawing of the client—the breakthrough of trust that allows significant emotional self-disclosure
- Providing emotional support and cognitive structures in follow-up to the expiation of shame, guilt, rage, etc.
- Overcoming the tendency of clients to define their identity through dependent relationships with others, particularly abusive men
- Shaping treatment activities for clients that take into consideration their drug-induced neurological deficits

- Preventing sabotage of treatment either through enabling behavior of co-dependents or active efforts to precipitate relapse by addicted peers
- Encouraging experimentation with new and more healthy behaviors in both parenting and adult relationships
- Identifying, as part of the relapse prevention planning process, those situations and emotional stimuli most likely to trigger relapse behavior
- Overcoming separation fear during termination; overcoming belief by client that change came from program not from within herself; and addressing fear of relapse

### 4.3 The Need for a Developmental Model of Recovery for SAFE Women

Considerable work has been done in recent years on the developmental stages of addiction recovery (Prochaska, et al., 1992). As early as 1988, the Project SAFE Program Manual called for research to elucidate the developmental stages of recovery for women—and particularly for women who share those patterns of experience so often reported by Project SAFE clients. It was hoped that such research could answer the following questions.

1. Are there predictable changes in emotional health that mark progressive time periods in the recovery process?
2. Are there predictable time periods at which points of change in emotional health that constitute high risk periods for relapse?
3. Are there predictable and desirable stages through which recovering women address emotional trauma experienced in their life, *i.e.*, childhood sexual abuse?
4. Are their identifiable stages and timelines that mark the emotional reconstruction of the mother-child relationship during recovery?

5. Are there phases that mark the restructuring of family members' roles during recovery? If so, what are these stages and over what period of time do such transitions occur?
6. Are there predictable stages or crises in the client's reconstruction of her social world and daily lifestyle following treatment?
7. What post-treatment recovery support services have the greatest impact on enhancing client and family health and reducing the risk of relapse?

It was hoped that the exploration of questions like the above would facilitate construction of a modularized service system in which the types and intensity of services could be matched to the unique stage of personal recovery in which each woman presented herself. Such a system would allow us to simultaneously focus on the types of service needs and the best timing of particular services. Clinicians working within Project SAFE were interviewed regarding their perceptions of such stages. These perceptions were incorporated into a widely distributed paper entitled "Project SAFE: A Developmental Model of Recovery." This recently updated paper appears in the appendix of this report and stands as the best summation of the recovery processes experienced by women treated within the SAFE model.

One of the most difficult issues to address in the treatment of women in Project SAFE was when and how to best respond to issues of trauma and victimization that emerged so prominently during the treatment process. Histories of physical and sexual abuse, traumatic losses, suicide attempts, violence to others, compulsive involvement in toxic relationships, drug-induced sexual promiscuity and other sources of emotional pain were commonly reported by our clients. How do we respond when, within the safety of the

treatment milieu, the full emotional intensity of such experiences are expressed for the first time? One could posit that such issues as incest or childhood sexual abuse must be addressed in primary treatment, that they are part of the dynamic that drives excessive drug consumption, and that failure to address such issues will inevitably result in these women seeking emotional solace in the self-medicating effects of alcohol. Another view argues that the personal defense structure in early recovery is quite fragile and that premature efforts to address extremely painful areas of life experience may not only not support recovery, but precipitate relapse. The latter view suggests that focusing on such issues in early treatment is a diversion from the needed addiction recovery focus and that dealing with such painful issues is a developmental task for later rather than early recovery. Each Project SAFE treatment program had to, on a woman-by-woman basis, decide which of the above stances was most clinically appropriate. When asked to articulate a position on the above issue, treatment staff seemed to chart a middle course that can be briefly summarized as follows.

It is important during the treatment of addicted women to identify traumatic life events and to provide opportunities for the initial expiation of emotion surrounding such events. The purpose of such identification is not to reach full resolution and emotional closure on such issues, which is probably unattainable during early recovery. What is needed is a framework of understanding that many addicted women will be experiencing parallel recoveries from different experiences that have dominated their lives. The goal is to integrate the stage-specific tasks of these recoveries within the context of addiction treatment. Addressing issues of victimization at a timing and level of intensity dictated by the client is crucial in isolating the self-defeating patterns of thinking, feeling, and

behaving which have been imbedded by these experiences. Addiction treatment must focus first on arresting the process of active addiction, but in so doing, it must provide a cognitive framework to address emotional trauma.

#### **4.4 Empowerment**

When Project SAFE staff are asked to define the most central theme of treatment services for addicted women, they most often respond with the word, “empowerment.” Treatment begins where the addicted woman is and seeks to empower her to acquire knowledge and make decisions enabling her to achieve her greatest potential as a woman and a mother. Beginning with what she brings to treatment, the chemistry of treatment seeks to empower her to move along continuums like the following:

- From self-hatred to self-acceptance to self-love
- From guilt and shame to forgiveness of self
- From anger and rage to forgiveness of others
- From compulsive dependence on substances and people to self-reliance
- From learned passivity to self-assertion
- From secrecy and deception to honesty
- From “intensify” to “simplify”
- From fear to faith, and
- From rejection of motherhood to pride in motherhood

Our experience with Project SAFE clearly underscores the contention that service delivery to alcohol and drug dependent women must involve the transfer of power.

#### **4.5 Treatment Burnout and Treatment Retention**

Sustaining the presence and emotional involvement of women in Project SAFE, both

during I.O.P. and during aftercare, is a major challenge at all of the sites. The issue is one of treatment burnout. The question is: how do we get women to stay involved in a high intensity treatment structure for a sustained period of time who have no prior experience with such sustained commitment to anything other than their drug use? There is also a danger of burnout from the multiple “system demands” being made upon these clients. The latter must be carefully balanced to prevent exhaustion and a sense of hopelessness of meeting all the demands.

Project SAFE staff continually experiment with new ways to continually re-energize and re-motivate clients to sustain their involvement in treatment and recovery activities. Some sites find that periodic respite from the routine treatment structure is helpful. Picnics, renewal retreats, and field trips have proved to be positive experiences. Outreach workers play a significant role in helping to re-motivate clients and there are times that it is helpful to reassert external control factors when a client is threatening to disengage from treatment. Clients are also reminded of the stakes involved in succeeding or failing treatment, e.g., child custody. Joint meetings with the client/family, the treatment site, and child welfare agencies often serve to reaffirm the goals toward which the client is working. These reminders usually result in improved participation.

#### **4.6 Duration of Treatment Contact**

Traditional residential and intensive outpatient substance abuse treatment programs are designed as short term intervention models. They are rehabilitation models designed to help clients regain their personal health and social functioning where such health and functioning have deteriorated due to the progression of alcoholism. Such models are questionable with clients who have no prior levels of effective functioning to fall back

upon. The Project SAFE treatment design began as a rehabilitative model and was progressively stretched and adapted to more aptly fit a habilitative model of intervention. The initial 4-5 week projections of client treatment involvement were based on the experience with clients very dissimilar from those who entered Project SAFE. Programs consistently found themselves extending lengths of stay to fit the needs of Project SAFE clients. Why was this extension process required? Project SAFE women entered with greater levels of denial, distrust and hostility than the more typical addiction treatment clients. They presented multiple problems and areas of impairment that required intensive case management activities. They possessed little if any healthy social network which could be utilized to support long term recovery. In the words of one Project SAFE worker, "I don't feel like I'm treating alcoholism; I feel like I'm building a whole life from scratch!" Three things are clear from our Project SAFE experience: 1) the service delivery model needs to be habilitative rather than rehabilitative; 2) both the period of intense addiction treatment intervention and the period of sustained recovery support services need to be extended beyond their traditional norms which have been established for much higher functioning clients; and 3) indeterminate (individualized by client need) lengths of stay are much more appropriate than preset lengths of stay for Project SAFE clientele. Our experience over the past sixteen years confirms the need to alter Project SAFE from an acute, short term intervention model to a sustained model of recovery management. Today, the average length of time from intake to graduation in Project SAFE is 50 weeks, with an average of 38 weeks of involvement in intensive outpatient services.

#### **4.7 Graduation**

A formal graduation ceremony following successful completion of intensive outpatient treatment was a ritual that evolved early in the history of Project SAFE. The ritual brought

together the treatment community, and a woman's family and social network came together to celebrate her successful completion of treatment. During the years 1988-1990, these rituals grew both in size, pageantry and emotional intensity, and became one of the most talked about facets of Project SAFE. During the 1990s, several sites began to rethink the use and meaning of the graduation ritual. There was concern that graduation was a metaphor that communicated that the process of changing was over, a fact underscored by the propensity for women to drop out of aftercare following their graduation ceremony. There was also concern that clients were going from this wonderfully intense daily support to almost nothing. Graduation began to be experienced by some clients as abandonment. The primary focus of concern was that the client went from 16-20 hours of treatment structure per week to only a few hours of structured support per week. This precipitous drop was disruptive to the recovery of many clients.

Most Project SAFE sites are hosting one to two graduations per year. Project SAFE sites averaged 19 graduates in FY 2002.

There are many variations in how the Project SAFE sites now handle graduation ritual. Most sites are developing more formal phases through which clients move in stages from the high intensity of intensive outpatient treatment to less frequent and intense outpatient and aftercare services. Most sites have moved the graduation ceremony until after the completion of aftercare and parenting classes rather than at the completion of I.O.P. This has helped offset the client's propensity to disengage following "graduation."

The current concern about graduation is the number of women who successfully complete I.O.P. but don't get through all of the aftercare sessions to qualify for graduation. In many cases, this lack of participation is more a

function of treatment “burnout” than an indication that the women has returned to a lifestyle of drug use. As one SAFE worker noted:

*Our clients just get burned out from the sheer volume of service activity. They're coming here 5 days a week, expected to go to meetings at night, and squeeze in a hundred appointments with other agencies in between. They just get overwhelmed. There is a fine balance of how much we can ask of these clients.*

With this recognition, there is a move to hold the graduation closer to the mid-point of aftercare, or to shorten the expectation for the duration of aftercare, for clients who are in stable pattern of recovery and have developed strong sobriety-based support structures.

Variations in graduation philosophies and practices are revealed in the following comments from Project SAFE staff.

*We do a graduation twice a year from our day program, with up to 10 women graduating each time. Because they've done so much work they get a plaque. In the evening program we have graduation 4 times a year, but it's scaled down, with a potluck dinner and a certificate (NICASA).*

*Our Graduation ceremony is at the completion of level 2 and level 1. We try to hold it in the same month as she completes the program. We have a luncheon with certificates and flowers—a big celebration (Franklin-Williamson).*

*Graduations take place after our clients have completed the bulk of SAFE, including education and parenting, and while they are in the phase of applying the skills and utilizing the resources they*

*developed in treatment. They graduate and continue 3-5 months of individual counseling and case management at home, gradually phased down to 1-2 hours a week. We graduate about 5-8 people quarterly (Triangle).*

*We do 2 ceremonies a year, with 30 women each time. We make it a formal deal on a Friday afternoon. There's a processional, singing, speeches and gift-giving. Family members and people in their support system come up and speak in support of them and the staff sing to them. It's a very moving and powerful ritual One thing we're proud of is that former clients come back and present roses to the grads as part of their incoming procession (Rosencrance).*

#### **4.8 Alumni Mentoring**

One of the unique aspects of Project SAFE is the growing practice of involving graduated clients in service work with women currently in treatment. Such service work ranges from giving lectures, serving as a mentor or sponsor for clients, participation in graduations, and just dropping in to offer words of encouragement and to put a face and voice on long term recovery in Project SAFE.

#### **4.9 Continuing Care**

One of the lessons learned in Project SAFE is that the early recovery of Project SAFE women is fragile. Project SAFE clients are vulnerable to emotional or chemical relapse during any major changes in the structure they are using to sustain sobriety. Changes in daily structure such as a shortened treatment day, a holiday, or the absence of a counselor or outreach worker all provide opportunities for regression during the early days of treatment. The shift from intensive outpatient treatment to aftercare marks a major disruption of this

structure and constitutes a high risk period for relapse. Most programs are managing this transition by slowly, rather than abruptly, phasing the client from the high structure of intensive outpatient treatment to the traditionally low structure of continuing care support groups.

As experience increased within each Project SAFE site, there was a growing emphasis on the kind of long term support structures SAFE clients needed to sustain their chemical health and family health. This emphasis has led to increased attention on the nature of support services that follow completion of the formal intensive outpatient treatment program. Variations in philosophy and approach included the following:

- the mainstreaming of Project SAFE clients within the substance abuse treatment agency's client aftercare groups;
- the development of a SAFE-specific aftercare track;
- the development of a menu of aftercare activities from which each client can select the combination that best meets her needs;
- increased emphasis on shifting support functions from the agency site to community-based recovery support groups;
- the use of an open-ended, long term, sobriety-focused aftercare group as an adjunct or alternative to traditional recovery support groups; and
- the development of a parenting-focused aftercare system in which parenting training classes and parenting support groups become the primary post-treatment support structure.

Aftercare programs play an important role in relapse prevention and early intervention into relapse events. There is a consistency across project sites on those circumstances that pose a high risk of relapse both during and following treatment. Project SAFE clients are at a high

risk of relapse when they near completion of the program. Staff attribute this risk to a fear of the loss of both support and success and the assumption of new responsibilities. One client who had done very well in treatment relapsed the day before her graduation. Events that add sudden responsibilities such as the return of children from placement or the birth of a child posed risks of relapse as did the experience of loss, e.g., abandonment by intimate partner, or death of loved one. Clients are also at risk when they experience a change in daily structure or routine such as holidays or check days. A final, but most important, factor in client relapse involve acts of sabotage (including coerced use) from intimate partners. Acts of coercion and violence in these relationships are particularly disruptive, often triggering the vivid recollection of earlier emotional/sexual trauma.

As these circumstances become more clearly understood, Project SAFE sites are building in increased levels of client support to reduce vulnerability for relapse. All clients in Project SAFE participate in the development of an individualized aftercare plan prior to their discharge from intensive outpatient treatment. Each plan addresses the nature and number of continuing care activities that the client plans to involve herself in to sustain the gains made during treatment. The most frequent components of aftercare plans are attendance at aftercare groups, attendance at self-help meetings, and individual or family counseling. There is also a much greater utilization of recovery homes or other sober housing arrangements as part of the SAFE continuum of care.

The differences in the structured aftercare programs of the Project SAFE treatment sites were minimal. The most frequent structures included outreach worker follow-up by phone or home visit, weekly client participation in a 1-2 hour aftercare support group, and regular

## Project SAFE

self-help involvement. In some sites clients continued participation in specialized women's support groups in addition to aftercare and self-help meetings. Clients were normally expected to continue aftercare from 3 months to 1 year depending on the service site. In FY 2002, 47% of Project SAFE clients attended 5 or more aftercare sessions following their graduation.

Perhaps the most powerful form of aftercare is encouragement for continued contact (for personal support and to provide support to other SAFE clients) and knowledge that a client can return on any day for support without having to go through a formal re-intake process and pounds of paperwork. The following statements reflect the diversity of approaches to continuing care in Project SAFE.

*At NICASA, we let our clients know that, if they need a tune-up, they can come back any time. When they do come in, we assess what they need and work out a plan and a schedule to get whatever type and frequency of support they need.*

*We leave door the open for our clients to come back any time. We view their children as alumni too. We do a newsletter and invite them to all our functions, circus, picnics, etc. We also have an aftercare track for kids. We have to look at their schedules, too.*

*We have aftercare and outreach at LSSI, and we continue to work with them even though they've graduated. We call them or they call us, and we do home visits, and connect them with different services even though they've completed the program.*

*At Robert Young Center, we monitor our women for at least two months after graduation with phone calls or having the*

*outreach worker just stopping by to check up on them.*

*We have a continuing care person who works on both Project SAFE and Next Step. We provide transportation and child care for aftercare sessions and on Thursdays the ladies have breakfast together.*

*For 3 months we've been doing alumni groups, and that's going extremely well. These are general alumni of Rosecrance, not just SAFE. We need to break that group in half, because it's huge. The alumni had their elections, and both the president and vice president are former SAFE clients.*

### 4.10 Mutual Aid Involvement

Project SAFE utilizes a wide variety of mutual aid support groups for its clients. These include traditional Twelve Step groups (Alcoholics Anonymous, Narcotics Anonymous, and Cocaine Anonymous), as well as their family adjuncts (e.g., Al-Anon, Alateen, and Alatot). The sites have also encouraged the development of gender-specific recovery programs (women's meetings within Twelve Step groups, Women for Sobriety and Kasl's Sixteen Step Empowerment Program), youth-oriented recovery programs (Teen-Anon), and secular alternatives to A.A. (Secular Organization for Sobriety and LifeRing Secular Recovery) as well as explicitly religious programs of recovery (One Church–One Addict, Alcoholics Victorious).

All women involved in Project SAFE are oriented and introduced to the mutual aid groups within their local communities as part of their treatment experience. Overall, mutual aid involvement takes the following forms:

- exposure to variety of recovery meetings

- and members through on-site and community meetings;
  - expectations for attendance at a minimum of mutual aid meetings per week (ranging from two to six across the sites);
  - exposure to recovery-related literature;
  - encouragement to seek sponsorship prior to discharge from treatment;
  - assistance with resolving obstacles to mutual aid involvement *i.e.*, finding meetings that provide child care, transportation via assistance from outreach workers or sponsors and client car-pooling; and
  - utilization of former SAFE clients to chair or participate in on-site AA/NA meetings.
- and entering situation in which they don't know anyone;
  - the discomfort of many African-American and Latina clients in predominately White self-help meetings;
  - concerns for both psychological and physical safety in the meetings as the women move in and out of their homes at night;
  - emotional exhaustion from daily treatment attendance and other service activities; and
  - cultural prohibitions against self-disclosure (“putting family business on the streets”).

Even when such problems are overcome, Project SAFE women do not consistently bond to Twelve Step programs.

There is a general consensus with the Project SAFE sites that it is best for clients to be exposed to a number of different mutual support groups and given the freedom to participate in those within which they feel most comfortable. Such flexibility is important given the obstacles that exist for client participation in traditional Twelve Step groups. These obstacles include:

- a lack of geographically accessible meetings;
- a lack of evening child care and transportation;
- shyness of clients going to new locations

When we look at the support structures that Project SAFE clients are utilizing, we see diverse pathways of support for long term-recovery. Twelve-step program involvement is strongest in those cities with women's meetings that are well-developed and exist within the client's own ethnic community.

Twenty-one Project SAFE sites responded to a survey about the mutual aid activities of their clients. The table below portrays the availability of various support structures within the communities in which the Project SAFE sites are located.

Support Group	Percentage of communities at which available
AA	95%
AA Women’s Meetings	90%
AA in languages other than English	65%
NA	100%
NA Women’s Meetings	55%
CA	71%
WFS	5%
SOS	11%
Church/Addiction Ministries	55%

The twenty-one sites were also asked to report the “primary sobriety-based support structures” that their clients were utilizing. These figures are presented below.

“Primary Sobriety-based Support Structures Utilized by Project SAFE Clients”	Percentage of Clients Reporting (More than one choice was possible)
AA/NA/CA	60%
Church	31%
Family	16%
Solo Recovery (sober without affiliation)	10%
Secular Organization for Sobriety	.005%

Individual responses across the SAFE sites show the varieties of ways in which the women in Project SAFE are developing sobriety-based support structures.

*We really need something like WFS. A lot of women are having trouble with 12 step groups, and we would like to start a WFS group here on campus.*

*AA and CA are used primarily, but a lot use the church as well. Most of the women go to AA meetings; if they start CA it’s usually really late in treatment. Some try*

*to use church as their primary source of*

*support, but we push them to do 12 step primarily while they’re in treatment. A lot who are out of treatment are using church as their primary support.*

*It’s about equal, church and 12-step groups. The ones who are doing best are the ones involved in both. We have church based recovery programs, at two churches here in town, and they’re even providing transportation; we have handouts from them. They don’t understand addiction to my satisfaction. Some of my ladies have church mothers, who take them under their wing, and that’s good for them.*

*Since the mid-1990s, 10-12 churches have*

*instituted 12-step groups on that level for the churches, and some are using just that. Some are using that and NA or AA, and some in the long-term just used church.*

It was observed early within the Project SAFE experience that many women, particularly African-American women, used participation in church as an adjunct or alternative to A.A./N.A.. In urban communities of Illinois, many African-American churches have organized recovery-based support groups that meet at the churches. Relationships are strengthening between several project SAFE sites and local community churches, and many of these churches are extending a welcome to Project SAFE clients. One of the advantages of churches is that children are either welcome at the meetings or child care is provided. However, two Project SAFE sites offered a less positive assessment of church as a sustainable sobriety-based support structure.

*We've seen ladies who graduate stay engaged in recovery if they're in AA. Some use church, but there tends to be a high recidivism if there's no AA.*

*We strongly encourage AA, NA, and CA. AA is strongest. A lot of women are resistant and want to use church. We don't try to discourage that, especially for African-American women because of cultural factors. But we find if they disengage from meetings, there's usually more recidivism.*

What seems to account for this divergence of opinion on the viability of church is whether there are special recovery-focused ministries. In communities where such ministries are an active part of one or more local churches, the viability of church as a recovery support structure is judged much more positively than in communities where SAFE clients attend churches without such a specialized support

program.

*We hook up with churches who have recovery-based programs. In East St. Louis there are at least 7-8 churches with such programs. That's really encouraging. You have to be selective. Not every church is supportive of recovery.*

The involvement of SAFE women in this self-help process is not always an easy process. Rural sites such as Marion suffered from a lack of geographically accessible women's support meetings. Cocaine- and heroin-addicted women were not always welcomed at AA meetings. Some women misconnected with AA because of failure to master traditional self-help etiquette, e.g, getting to meetings on time, staying on topic, summarizing briefly, listening, etc. Some women had their fragile hold on the self-help process disrupted by "recovery romances." Some women were in communities where going out at night to attend self-help meetings was not safe.

Where local self-help resources do not exist, some SAFE sites have used continuing care groups as a culture to germinate new mutual aid groups. This is done by running open-ended continuing care groups that are supervised by a professional staff person but run to the greatest extent possible as a self-governed support group. As the continuing care group matures, staff encourage group members to evolve into a formal mutual support group.

Project SAFE women have two major areas of their lives in which they need support, one for continued recovery from addiction, another for effective parenting. What if a special long term support group was offered at your agency for recovering women who wanted to get together and talk regularly about special problems and concerns related to parenting? What if that

group eventually evolved into a self-help group, or sub-group within A.A./N.A. or W.F.S., focusing on the twin issues of quality sobriety and effective parenting? Sounds exciting, doesn't it! That's where several informants think the future of continuing care within SAFE will evolve.

#### **4.11 Best Practices and New Service Initiatives**

When staff of Project SAFE were asked to describe the best practices within their sites, they consistently noted the model itself: the multi-agency, interdisciplinary collaboration; the aggressive outreach; the gender-specific treatment; and the parenting and child support services. The following are among other prominently noted best practices within the Project SAFE sites in FY 2002.

##### ***Individualization***

Since the earliest days of Project SAFE, one could hear the declaration, "Project SAFE is not a model; it is a commitment (to assess needs and let those needs dictate service response)." The flexibility that comes from this individualization is a source of great pride among Project SAFE staff.

*The flexibility we have in our SAFE program is what we do best. We move her back and forth from level to level depending on her needs. They are all treated like what they are, individuals. If they're coming in 4 days a week to IOP and they get a job, we offer them evening groups. We have morning, afternoon, and evening groups. We provide transportation and child care—whatever it takes.*

A distinctive element of Project SAFE is the continual level of innovation in response to changing client needs. When HIV risk increases, HIV risk assessment for all clients entering Project SAFE is initiated and the Visiting Nurses Association is enlisted to

discuss sexually transmitted diseases with SAFE clients. When literacy problems arise, programs link to literacy programs and acquire tapes and volunteer readers. This is all a way of saying that the responsiveness and flexibility within the SAFE sites is one of their strongest attributes.

##### ***From a Program to a Treatment and Recovery Support Menu***

Recognizing the diverse needs of its clients and the legitimacy of many pathways and styles of recovery, Project SAFE sites are striving to create the widest possible menu of treatment and recovery support services. Project SAFE has evolved from an intervention model that focused on a single level of care (intensive outpatient) to a model that moves clients through multiple levels of care based on their evolving needs and responses to various treatment interventions. These expanded levels include detoxification, treatment readiness groups, residential treatment, and traditional outpatient treatment. Forty percent of Project SAFE clients were involved in other levels of care in addition to intensive outpatient during FY2002.

##### ***Continuity of Contact / Managing Dependency***

Project SAFE has emphasized the principle of continuity of contact in a primary service relationship at the same time it has attempted to actively manage untoward effects of client dependency upon a single worker by taking a team approach and making other staff available to the client, as well. The continuity of contact is most exemplified in the relationship between the outreach worker and the client. The outreach worker maintains an evolving relationship with the client from the point of initial contact until the client's final disengagement from contact with the program. The potential negative effects of dependency are recognized and actively minimized.

*When we have long-term stays, we get dependency issues. In response, we've beefed up our team approach to treating individual clients. We have tried to develop interchangeable functions so that if one person isn't available, another one is. When people start transitioning to continuing care, our emphasis on empowerment increases even more than earlier. It isn't just a close relationship with the outreach worker or one counselor. By spreading our influence, each woman is more likely to experience the success of her own work and achievement.*

### **Low Threshold for Continuing Support or Re-entry**

Project SAFE has found a way to lower its threshold of engagement by minimizing the procedures and paper required to get continued support services or re-access those services once they have terminated. The message is simple and clear: Come back before you relapse; come back if you relapse. Keep the recovery process moving forward.

### **Motivational Enhancement Interviewing**

A new clinical innovation in the field of addiction treatment that is being used widely within Project SAFE sites is motivational enhancement interviewing as developed by Miller and Rollnick 1991. The non-confrontational nature of this approach is very congruent with the gender-specific philosophies of the Project SAFE sites.

*Motivational interviewing has made enormous changes for us. We've had trainings, and a commitment from the whole agency, including on training on an ongoing basis, meeting the client where she's at, being lot more flexible with clients, letting them feel empowered. It's making a huge difference. It might take longer, but it's so positive in the end (White Oaks).*

### **Praise and Contingency Management**

There is a growing body of literature on the use of praise and contingency management in the treatment of addiction. Both are tools used by Project SAFE sites.

*We praise the littlest thing. If they attended one week of treatment, we make that sound like they went to the moon. We ask about the family, I have pictures of all their kids in my office, on the bulletin board. We're trying to gain a rapport with them, then we can work on the meaty, tough issues. I let them know how glad I am to see them, say "come on in." I draw them in with warmth first, and try to enjoy the process.*

One of the Project SAFE sites (Breaking Free) is using a formal process of contingency management.

*We have a success shop. Everything clients do that supports sobriety and healthy living earns points for them (e.g., if they bring their sponsor in for a meeting, if they go to a 12-Step meeting). They're allowed to go shopping at the success shop one day a week. A lot of churches donate clothing, toys, candy, women's clothing, makeup, etc. The women love going in there, and they have competitions about who's going to get the most points.*

A description of Breaking Free's approach to contingency management is included in the Appendices.

### **Community Service Activities**

Some Project SAFE sites are finding creative ways to involve Project SAFE clients in service activities within their communities.

*In our agency we do a lot of prevention work with teens, using some of the Project SAFE women as role models. We're the safety net. It's almost like Scared Straight.*

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*The kids are “convicted” by a peer jury, and they’re sentenced to sit in on a Project SAFE session. The women will tell them their story, and tell them why they don’t want to go down that road. The women feel very honored, and the kids respond very well. This is part of another Breaking Free program, a peer jury program. It’s for a first offense, where they admit their wrong-doing. These are not long-term offenders, and usually not violent. They’re substance abuse-related offenses, and community service hours are given as restitution.*

### ***Job Development***

With more women in Project Safe facing pressure to move from welfare to work, several Project SAFE sites have incorporated education and vocational training into their program. This includes linkage to formal education and training programs, resume preparation, practice completing applications, job interviewing skills, and coaching on job etiquette.

### ***Art Therapy***

The potential use of art therapy within the treatment activities of Project SAFE has been

a topic of discussion at SAFE meetings for some time, but few resources existed to really begin such integration until recently. Several sites are now experimenting with different forms of art therapy. These range from the creation of recovery quilts (Rosencrance) to the use of finger painting with the children (NICASA),

### ***Alumni Groups / Alumni Mentoring***

A number of the Project SAFE sites utilize Alumni support groups as part of their continuing care activities and an even larger number of sites have found creative ways to use Project SAFE graduates to support new Project SAFE clients. The most frequent mechanisms of support are to use alumni to mentor particular clients or to involve alumni in telling their own recovery stories to newly arrived clients.

### ***Recovery Advocacy/Resource Development***

SAFE staff are taking a more activist stance to address the unmet needs of their clients and families. For example, staff of several sites are part of coalitions working to create safe and sober housing for women and children.

## Chapter Five:

### Parenting and Family Services

#### 5.1 Introduction

Although the term “Project SAFE client” is applied to the woman who has been referred to the project for services, there has been a growing conviction that the larger client is the family itself. And as vulnerable as most clients may be under their often-tough exteriors, Project SAFE staff and leadership are aware that the most vulnerable members of the family are the children. Project SAFE begins to address the needs of the family through parenting training and through a variety of services to the families of SAFE women. This chapter outlines those services in two major categories: parenting training and services to children and family members. Both types of services were stressed as essential in the focus groups conducted in preparation for this report, and both were cited as best practices in responses to the 2001 Project SAFE Survey.

#### 5.2 Parenting Training

Parenting classes have been offered as a contractually required component of Project SAFE since the program’s inception. Most sites have provided this training as a specialized track within Project SAFE, and some sites have brought in outside trainers or contracted out to other agencies for parenting training. Beginning in the mid-1990s some sites expanded their parenting training to other OASA/DCFS Initiative clients, in some cases including men in the training audiences.

Following are general overviews of:

- training logistics,
- parenting training staff,
- parenting curricula used,
- special features and activities used at various sites,
- challenges in parent training, and

- recommendations and best practices for parent training.

#### Training Logistics

It is up to the individual site to determine the point in the client’s progress at which parenting training begins. Focus group participants reported a variety of starting times or criteria, including:

- when clients start their treatment in Project SAFE,
- four to eight weeks into their treatment,
- one month after they become abstinent from alcohol and other drugs,
- when they leave IOP and enter the regular outpatient modality, and
- during aftercare.

While it would be very helpful to individualize the timing of participation in parenting training for each mother involved with Project SAFE, there was overwhelming consensus across sites that parenting training should begin toward the end or after the completion of intensive outpatient treatment. The sites that offer parenting training earlier often do so because of client attrition and the fear that clients will leave treatment without any exposure to parenting training.

Project SAFE staff across the state have voiced the belief that concurrent involvement in substance abuse treatment and parenting training may be inappropriate for many clients. This is particularly true when:

- the continued neurological deficits (e.g., the impairment in concentration skills and memory associated with post acute withdrawal syndrome) inhibit the acquisition and retention of new

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knowledge and skills during early recovery,

- the concurrent treatment and parenting training result in emotional and cognitive overload, decreasing the amounts of energy available for both activities, and
- the mother has not achieved sufficient emotional stability to defocus off herself and onto external relationship responsibilities.

Project SAFE sites are contracted to provide 16 hours' parenting training to each client. Most sites offer parenting classes one day a week, for two to two and a half hours each session. The number of sessions varies from site to site, ranging from eight to eighteen weeks.

Most sites offer parenting training on site. A few others, primarily smaller agencies without the resources to invest in a parent trainer, use outside resources. In the words of one focus group participant, "It's very individualized. They will go into the home and do parenting at home, and refer the women to four different agencies, with different parenting programs. We try to access whatever we can." Some sites have parenting training on site and still refer women to outside training resources if they believe her needs would be met more effectively there.

### **Parenting Training Staff**

Most sites have one on-site staff member who conducts all parent training. This position may be filled by a variety of people, including a parenting therapist, the parent coordinator for the program, the prevention director, or (in a few cases) an outreach worker.

Whether or not they are directly involved in parent training, outreach workers have played a key role both by serving as parental role models and by serving as in-home parental

consultants to Project SAFE mothers. There is a unanimous belief that this role has helped increase both the acquisition and application of the knowledge and skills acquired through the Parenting Training curricula. Such in-home support may be essential for substance-abusing mothers to generalize and apply concepts from the classroom to concrete parent-child incidents occurring in the home. When multiple people (e.g., outreach workers, homemakers, etc.) are involved with the client in the home, it is also important that great care be taken to ensure that parenting principles from the classes are being interpreted consistently by the various service workers and that the workers clarify their respective roles related to in-home services.

The parent trainers at many sites have been trained in parent training and in the curricula they are using (In 79 percent of the sites responding to the 2001 survey, parent training staff had participated in training related to this role during the past year). Some have related professional education and/or certification. However, many focus group participants said that they would like more training for their parent training staff. This was particularly true of the sites that are using outreach workers in this role. Staff from many sites said their parent trainers would appreciate and benefit from an opportunity to gather with those in similar positions at other sites, perhaps in a special track at the annual conference.

### **Parenting Curricula**

In discussions of the parenting curricula used with Project SAFE clients, three points become clear:

- many different curricula are in use;
- staff are highly enthusiastic about the curricula they are using and clients' responses to them; and
- parenting trainers at many sites are taking considerable initiative in customizing

curricula and combining elements of different curricula to fit the needs of their clients.

This “mix-and-match” approach is exemplified in the comment of one participant: “There’s not one model that fills all their needs. We’ve done a collective parenting model to try to include it all, including parenting education, problem solving, and some of our other curricula.”

Many sites use all or part of a curriculum developed by the Illinois Department of Children and Family Services designed to meet the unique needs and characteristics of parents involved with the agency. The curriculum was specifically designed for parents who were single women between the ages of 25 and 35, who had up to three children, who were supported by ADC, and who were involved with DCFS because of child neglect. *Effective Black Parenting* and the *Nurturing Program* are also widely used at Project SAFE sites. In addition, a number of other new and standard parenting curricula are used in Project SAFE sites, some blended together and blended with exercises developed by site staff.

According to the 2001 survey, parenting curricula currently in use (and the percentages of sites using them) are:

- DCFS Parenting Curriculum (29 percent)
- Active Parenting Program (24 percent)
- 1-2-3 Magic Principles and Discipline (24 percent)
- Parent Effectiveness Training (24 percent)
- Effective Black Parenting (19 percent)
- The Nurturing Program (19 percent)
- Parents Healing: A Way of Learning (14 percent)
- Ages and Sages (5 percent)
- It Takes a Village (5 percent)
- Self Healing (5 percent)
- Other (33 percent), including:

- Caring, Connecting, Common Sense Approach to Parenting
- Curricula developed from various services
- Strengthening Families
- Parent Project NICASA
- Practical Parenting—Sammis
- Curricula developed from various services

A number of factors are influencing the evolution of the parent training approaches used in Project SAFE:

- Finding that maternal guilt and shame are major emotional obstacles to the learning process, several sites have begun their training classes with discussions that focus on social stigma, feelings about past parental shortcomings, and fears and aspirations about parenting.
- In the 2001 round of focus groups, many sites reported increasing levels of cognitive impairment, decreasing levels of literacy, and increasing problems with attention and concentration among Project SAFE clients. Problems of illiteracy and learning disability have forced some groups to defocus from written curricula and move to highly experiential modes of learning, e.g., videos, role playing, and focused discussions. The Decatur site, for example, began early in the program to use field trips to day care centers to illustrate age-appropriate behaviors of children. The Springfield site altered the pre-post test format to provide increased feedback to the mothers by developing pretests and posttests for each module of the curriculum.
- Given the neurological deficits experienced by substance abusers in early recovery, basic knowledge and skill training is probably best transmitted in small doses, spread over an extended period, with repeated testing of recall and a

high frequency of repetition for key concepts.

- Many Project SAFE sites have found their parenting classes evolving over time into more of a support group function, rather than a strictly educational function. These sites are exploring various group structures that can serve as ongoing self-help structures around parenting issues.

Sixty percent of the sites responding to the 2001 Project SAFE Survey reported that they assess clients' baseline knowledge before they begin parenting training, and 70 percent reported that they evaluate learning gains at the conclusion of training.

### **Parenting Features and Activities**

While most general aspects of parenting training are of critical importance to this population, the 2001 focus group participants named a number of practices and program elements that they had found particularly effective. These include the following:

- **Instructional Elements:**
  - A module for women who have special-needs children
  - Instruction on developmental milestones for children of different ages
- **Bonding With Children and Observation of Parenting:**
  - Bonding sessions with children as part of the parenting curriculum
  - Sessions in which parents are observed interacting with their children
  - Shared meals with mothers, children, and Project SAFE staff
  - Outings with mothers and children, to observe their interactions in outside settings
  - Videotaped interaction between the mother and children, taken over time, so that mothers can critique their own actions and see their own progress

- **Modes of Parenting Support:**

- A once-a-month parenting support session in which parents can talk about issues that have arisen
- Parenting support sessions in which counselors can help mothers apply recovery principles to their parenting issues
- Therapeutic parenting sessions, where women can work on ways in which their own therapeutic issues are affecting their children
- One-to-one sessions with a parenting therapist
- Special sessions in which family members can attend parenting groups and learn about ways in which their support is needed

- **Rituals of Affirmation:**

- A daily activity that mothers can do with their children, or something special they can tell their children each day
- Special ways of showing love for their children, e.g., making valentines for them
- A graduation ceremony for the parenting class

### **Challenges in Parent Training**

A substantial element of challenge in the design and delivery of parent training springs from the decreasing level of functionality of Project SAFE clients. It is not only cognitive and attentional skills that are weighing in at lower levels, but also basic living skills. This has some specific implications for parenting training.

Most sites have discovered that mothers need personal living skills and basic caretaking skills as a foundation for the traditional parenting training programs. Increasingly, Project SAFE sites are conducting training in housekeeping, cooking, grooming, dressing,

and social communication skills as a prelude to parenting training. This pre-parenting training also includes basic caretaking knowledge, covering everything from how to pack a diaper bag and prepare bottles to the importance of immunizations and realistic expectations for child development. As one participant said, “Sometimes they just don’t know what they’re supposed to do to be a good parent. Sometimes they can’t know.”

The reason for this lack of foundation becomes apparent when one carefully reviews the developmental histories of SAFE clients. Many of these clients, whether as a result of poor parental role models or the loss of parents through death or separation, have no experiential foundation for effective parenting. The cases that drive home most poignantly the intergenerational nature of this problem are the adult clients who were themselves wards of DCFS as children because of issues of parental substance abuse and neglect and/or abuse.

“Most of our women parent as their parents did,” said one focus group participant. “We had one woman who used to be forced to kneel on broom-handles with her hands behind her back. I stopped by her house one day, and here’s her little boy kneeling on a broom-handle. I picked him up and asked her, ‘What are you doing?’ She told me it was different because he didn’t have to keep his hands behind his back. But it’s still the same basic structure. So we have to start this all over again. The very worst thing that ever happened to them, they do it and feel worse.”

Given the double stigma of substance abuse and child welfare involvement, issues of parenting are already emotionally loaded for most Project SAFE clients. Addressing these issues in effective but non-shaming and culturally competent ways is a significant and important challenge for all who undertake this effort.

## Recommendations and Best Practices

Throughout the years in which Project SAFE has been in existence, program staff and leadership have provided a wealth of information contributing to a best-practices approach toward parent training. The following is a summary of ideas and recommendations that have been offered.

- Assess the curricula in use for simplicity, understandability, developmental sequence, required literacy, interactivity, experiential opportunities, repetition, and integration of information. Promote curricula that make the learning process easy.
- Take care to ensure that the curricula and methods used are culturally competent for the clients using them.
- Address issues of stigma, shame, and self-worth very early in the parent training process, to ensure that clients will experience parent training as a positive aspect of treatment, rather than a shaming one.
- Address the basic skills of child care and self-care that many clients lack.
- Include non-shaming material on the effects of specific substances of choice on children (e.g., cocaine, methamphetamines), and some of the developmental and behavioral implications of prenatal exposure to these substances.
- Begin parent training as late as possible in the client’s progress through treatment and aftercare. If issues of attrition seem to dictate a more rapid introduction of parent training (for fear of losing clients before training begins), address those issues separately.
- For clients who are still in treatment when they receive parent training, integrate that training into treatment, and integrate treatment principles into parent training.
- Integrate parent training into clients’ home and family lives, through the work of the

outreach workers and, if possible, through special in-home visits by parenting trainers.

- Continue the supportive approach toward parent training, including one-to-one sessions and parent support groups in which clients can work on specific issues.
- Promote a sharing among the sites of the special features that they have found most effective, including those listed in section 1.4 of this chapter.
- Promote greater networking in general among parent trainers from multiple sites, including a parent training track at the annual conference and regional gatherings of parent trainers.

### 5.3 Services for Children and Families

Since the inception of Project SAFE, its primary focus has been on the mother. The original program design sought to improve the health of the children and the family unit by supporting the mother's recovery from addiction, by improving the mother's emotional health, and by increasing the mother's parenting skills. Some child- and family-focused services do exist within Project SAFE, but these often tend to be viewed as secondary to the mother's treatment. The range of child and family oriented services varies greatly across the SAFE sites. Family service components offered at various Project SAFE sites include:

- child care (on site or in the community) provided while mothers are in treatment sessions
- family education programs,
- family groups and counseling sessions,
- education/therapy/play groups for children
- in-home sessions with children
- groups for substance-affected children
- outings for children and for children and their mothers
- screening to determine children's needs and referral to needed services,

- referral to prevention and early intervention programs
- mother and child discussion and play groups
- family potlucks at the treatment site
- referral of clients and significant others to relationship counseling
- encouragement for partner participation in parenting training, and
- encouragement for family member participation in Al-Anon and Alateen meetings.

In responses to the 2001 survey, 79 percent of sites reported that they observed parent-child interactions in the treatment center and/or the home as part of parenting training. Ninety-five percent of the sites affirmed that they saw it as their responsibility to monitor the care and safety of children during home visits with Project SAFE clients.

Contact with family members is designed to achieve multiple purposes, the most significant of which have included:

- removing the unmet need for child care as an obstacle to treatment;
- educating the family about substance abuse and its impact on family life, and helping family members cope with their confusion and discomfort with the changes taking place;
- identifying and alleviating the emotional pain of family members;
- helping elder family members who are left to take care of young children;
- addressing any unmet clinical needs among the children of SAFE clients; and
- rebuilding family relationships, restructuring family roles, and recreating healthy family rituals.

In spite of the existence of some formal child- and family-oriented service structures, SAFE sites have encountered a number of obstacles over the years in their efforts to involve

families of Project SAFE clients. For example:

- Many clients' children are in foster placement which, while necessary for the protection of the children's welfare, sometimes makes it difficult to involve them in their mothers' treatment and change processes.
- Many of the women entering the project are estranged from their families or have no family members in the geographical vicinity.
- In many other cases family members are resistant or outright hostile to participation in group support or family services. This is particularly true where the adult partner (the husband or paramour) is alcohol or drug dependent and obviously threatened by and hostile toward the client's participation in treatment. Project SAFE staff have recognized the danger inherent in these situations and have worked patiently with clients to facilitate favorable outcomes, either through the partner's entry into treatment or through the client's realization that she must put some distance between herself and people who threaten her sobriety.
- the need for child care so that mothers could attend the basic intensive outpatient treatment program,
- the need for day care centers sensitive to and comfortable with special needs, e.g., apnea monitors for cocaine-affected infants,
- more sustained child care needs for mothers who had to be admitted for detoxification or residential treatment, and
- the need for evening child care to ensure mothers' access to local self-help meetings.

Programs have explored and adopted a number of child care delivery models as part of Project SAFE. These include:

- the random placement of children in any existing child care resources that have openings,
- the recruitment and development of new child care resources,
- the provision of child care services on-site at the treatment agency (present in 38 percent of sites),
- temporary on-site child care services while awaiting placement in child care, and
- the use of a single day-care center for placement of all children participating in Project SAFE.

The remainder of this chapter focuses on three areas of particular importance to Project SAFE: the provision of child care services, additional services needed by children, and future directions for family services.

### **Child Care**

The fact that child care was expected from the beginning to be a critical issue in the overall success or failure of Project SAFE did not lessen the intensity of this issue as it began to unfold in sites across Illinois. The need for child care is critical, and it has been revealed as a more specialized need than was expected. Specific needs that emerged in some areas have included:

Child care that is provided by Project SAFE sites is funded in a number of ways. Asked about the funding of SAFE-provided child care in the 2001 Project SAFE survey, nine sites reported that child care is funded by DCFS, and two reported that such care is funded by Lutheran Family Services. One site wrote that Public Aid funds its child care, one reported that its child care is funded by private donations, and one wrote that child care is provided under "contract by social services." (Two sites wrote "N/A," indicating that Project SAFE did not provide child care at those sites.)

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In detailed discussions across Project SAFE sites, it has become clear that sites need a menu of child care service development models that can be selected to fit local needs. Centralized child care at the treatment site has several advantages in urban sites, but the use of more geographically decentralized sites seems to have greater utility for rural sites serving a multi-county catchment area. The remainder of sites showed considerable ingenuity in seeking and finding child care for clients' children. Outreach workers were the staff members most often engaged in these pursuits, in some cases with the help of child welfare case workers.

Although in the 2001 focus groups some sites still reported general challenges in finding day care, the consensus among most participants was that the situation had improved in recent years. However, a few challenges are still in evidence:

- The search for child care is somewhat more difficult when evening care is needed, while clients attend self-help groups and working mothers attend night treatment sessions.
- Child care issues also grow more complicated during school holidays and during the summer for SAFE mothers who have school-aged children. These times require more outreach worker intervention to help arrange day care, and even with this assistance these are often periods of lower daily attendance in Project SAFE.
- Another issue raised by the mixture of young and older children in the same family is the impact of the age restrictions in many child care centers. This necessitates splitting the children among different child care resources, and places additional transportation burdens on outreach workers.

One benefit to having child care on site, or in a program that communicates well with Project

SAFE, is the feedback that child care can provide to both clients and treatment staff. Focus group participants provided some examples.

- “We see children not communicating well enough, not talking, acting out. We can get feedback to the group counselor.”
- “Our child care workers do observation forms, and the supervisors and counselors get them, to see how the verbal communication is between the child care worker and the client. Some women tend to defocus from treatment by checking on their children during groups. We can observe how many are running to child care to check on their babies.”
- “We had one client, and it was very helpful for that client. We had a videotape, recording the child's first word.”
- “We bring moms into day care to work with Pat, and it's a coaching process. They put on a new face in there. Some moms in the morning bring their kids in, and they're all crying, and mom wants out of there. So they do get a good handle on what we're dealing with.”
- “Some of our [clients] are very good with children, and they say, ‘I'm going to get skills in [child care]!’ So the clients are doing job shadowing too.”

### **Additional Services for Children**

“Some of our kids have seen too much,” said one participant in the 2001 focus groups. “They're intelligent, like little grown people, exposed to too much. They understand their choices: You have to raise yourself now.”

The needs of children whose mothers are in Project SAFE, particularly those children who reside with the mother, become apparent through discussions with the mothers and through observation of the children in the treatment milieu and in the home. The most visible needs at the time of admission range

from health needs (e.g., immunizations) to intervention in behavioral or emotional problems.

A number of SAFE sites are actively engaged in screening the children of clients and making internal or external referrals for the help they need. Of the sites completing the 2001 survey, 43 percent reported that they assess all children of Project SAFE clients for their need for special services, and 24 percent reported that they offer a special service track for children of SAFE clients. Some examples of children's services, activities, and referrals reported by focus group participants:

- NICASA's parenting specialist screens the children of SAFE clients and connects them with needed services. The agency also has a number of groups for children of different ages.
- Triangle Center has an adolescent program, including prevention, treatment, and early intervention, and encourages referrals of SAFE children to that program.
- Heritage Behavioral Health coordinates with the local prevention program. SAFE staff visit the junior high schools to see how clients' children are doing.
- Bridgeway works with the local public housing authority to help clients' children who live in public housing. They provide transportation to children's programs and spend time with the children to help them become involved in these programs.
- Comprehensive Mental Health Center of St. Clair makes a variety of referrals, tapping into an "underground railroad of kids' stuff" and sometimes bringing children on site to address special issues.
- Chestnut Health Center makes referrals to its early intervention program, asking clients if their children need help and encouraging them to give their permission for their children to receive help.
- Substance Abuse Services, Inc. (SASI) took part in a study by researchers at the

University of Chicago, before that study was terminated for lack of funds.

University staff came on site and worked with children on developmental issues. SASI also sometimes brings children in to participate with clients in arts-and-crafts sessions.

- White Oaks holds a number of groups for children of different ages, including children who are not in their mothers' custody.
- Franklin-Williamson Human Services has begun a group for substance-affected children ages seven to eleven, including some children of SAFE mothers.
- Robert Young Center has a children's initiative whose services are integrated with the mothers' parenting classes. The children have their own groups, combining therapy with fun.
- Rosecrance has a program for teenagers, some of them the children of SAFE mothers.
- Haymarket Center invites IOP day program clients to bring their children in, and to visit the children's program and participate in activities after their own sessions are through, as part of the family enrichment effort.
- Some sites honor children in their mothers' graduation ceremonies.

Another task of Project SAFE is to involve the children, and those agencies working with the children, in the changes the mother is undergoing. Three Project SAFE sites have received grants to provide specialized services aimed at enhancing the relationships between Project SAFE mothers and their children, and two of those grants (Robert Young Center in Rock Island and White Oaks in Peoria) are still in effect. Known as Project Joyous and SAFE Futures, this program began with a Federal demonstration project in the mid-'90s, and continues with state funds, monitored by the regional offices. The program focuses on:

## Project SAFE

- improving parent-child bonding;
- enhancing the emotional, cognitive, and social development of the children;
- offsetting the damaging effects of having lived with a substance abusing parent; and
- preventing child abuse and neglect.

Service components include therapeutic activity/play groups for children, mother/infant and mother/child therapeutic activity groups, and continuing care groups for children of different ages. As the project has developed, activities have become progressively more interactive, to respond to the learning styles of the children, and more opportunities have been created for involvement by older children. Staff from these projects have expressed the belief that this component has significantly enhanced the overall quality of Project SAFE, giving them more time to observe and coach mother-child interactions, both within and outside the treatment environment. One staff member observed how beneficial the child-oriented activities were for the mothers. It seems that most of the moms had never experienced going to a zoo, visiting a public library, going bowling or skating, attending a play, or visiting a museum.

Two of the ongoing issues regarding children's services are the problem of transporting children for evening services and the problem of persuading foster parents to allow the placement of children in SAFE activities.

Some of the agencies that house Project SAFE are in the process of expanding their services to children and adolescents, including those provided through the newly established Healthy Start Program. Several SAFE staff have expressed their hopes that the availability of these services will be of great benefit to the children of SAFE moms.

OASA is also exploring ways for agencies in the Initiative to use some of their funding to provide early intervention services to DCFS-

involved youth. During Fiscal Year 2001, Initiative agencies were encouraged to submit proposals for youth-specific programs that would emphasize early intervention services. OASA and DCFS have also created a screening instrument geared toward youth, and will continue to look at overall practice as it relates to youth.

The call for more systematic approaches to assessing and responding to the counseling and support needs of Project SAFE children has been heard in each of the evaluation meetings. There is hope that the experiences within the Project Joyous and SAFE Futures sites will provide direction for this needed area of service development.

### **Future Directions for Family Services**

Although many of the activities and practices described above qualify as best practices for services to families and children, the temptation with a subject this important is to press for ever higher standards by focusing on future directions. In general, best practices in this area tend to spring from an understanding of the devastation that addiction brings into the lives of family members, particularly the lives of children. The sites whose children's programs are truly exciting are those that honor and respect the value and the importance of these children, and show that respect by offering ongoing and visible recognition and support.

In studying Project SAFE over the years, evaluators have formulated a number of convictions regarding the directions in which the program's family services should evolve. The following is a sampling of those convictions.

#### ***Child Care***

While discussions of the mechanisms for child care have tended to focus on the mother's need for access to treatment, discussions of the

quality of child care have focused on the special emotional needs of SAFE children. While the models and mechanisms of child care may vary across sites, there is strong consensus that the following developmental activities would strongly enhance our response to the needs of Project SAFE children.

- An experientially based curriculum could be designed to teach children about substance abuse and addiction, its impact on the family, and the nature of treatment and recovery. The curriculum would be modularized for appropriateness as to content and learning methodologies across developmental ages. This curriculum could be utilized across child care models and represent a consistent child-focused service element within all Project SAFE delivery sites.
- A training curriculum for child care staff (plus child care institution staff and foster parents) could be developed that provided:
  - a Training of Trainers for the child curriculum;
  - specialized training on the effects of alcohol and other drugs on fetal, infant and child development;
  - specialized techniques on the care and management of drug-induced conditions, e.g., heightened irritability, hypertonia, hyperreflexia, etc.
- A protocol for bringing recovering mothers together with their children to actively facilitate relationship construction, e.g., teaching specialized care techniques, the practice of new parenting skills, access to effective role models, and mutual support with other mothers.

### ***Child Safety***

Staff in all facets of Project SAFE have expressed a special concern for the health and safety of the children of SAFE mothers. While a particular focus on assessing issues or conditions that might compromise the safety of children is natural and paramount for DCFS

workers, outreach workers and treatment staff had not been trained in such observation and assessment. Training of outreach workers and counselors by DCFS representatives in the project's early years helped strengthen this focus on child safety. Discussions in this area included such topics as:

- how to assess actions or conditions that threaten safety,
- legal clarifications of mandatory reporting and treatment confidentiality, and
- procedures for mandatory reporting.

As the system-wide provision of training for site staff has waned, it is time to re-examine the extent of staff knowledge on these and other child safety-related topics.

### ***Child Treatment***

Project SAFE staff have consistently reported the need to evolve an intervention design for SAFE children who present with serious symptoms of physical and emotional distress. Many of these children have immediate disturbances that must be addressed, and virtually all are at high risk for developmental problems. We often experience a sense of horror when we examine the family histories of Project SAFE women. We see a clear cycle of multi-generational transmission of substance abuse and addiction, impaired parenting, and emotional dysfunction that marks these families as far back as historical data are available.

We know from the research literature that the children of Project SAFE will be four to five times as likely to develop alcoholism and other substance abuse disorders as adults, compared to people without familial substance abuse in their genetic history. We also know that the family history of parental neglect and abuse increases the risk that these children, as adults, will themselves become neglectful or abusive parents. Where does it stop? Are there models that can be developed that can finally interrupt

and fully break this multi-generational cycle? Are there intervention models available now that might prevent the children of Project SAFE from needing a similar project in twenty years? We believe that research and service design resources must be boldly committed to these questions.

### ***Focus on Family***

There is a growing number of family intervention and education models that have evolved from substance abuse treatment programs around the country. Unfortunately, they are designed for clientele quite different from those involved with Project SAFE. These models have been designed primarily for the intact, white, middle- or upper-class family with a male alcoholic. Much more time will be needed before the experience of Project SAFE can produce a fully developed, replicable design for comprehensive family services for our clients. The universe that such a program might encompass is beginning to evolve in the minds of Project SAFE staff. Overall thoughts and recommendations concerning the need for family programming include the following:

- **Redefining “Family”:** We need to experiment with intervention and education models involving non-traditional family structures. Integral to this process is a clarification of the very definition of family. What do we do with paramours? Are they treated as if they were spouses? Where many non-family members may reside with the client, is “household” a more appropriate concept than “family”? Is “family of choice” a more realistic unit of service than “nuclear family” or “family of origin?” What about key individuals in the client’s social network who perform some parental or family functions and who may or may not be supportive of the client’s recovery? Educational material must have as its primary model the single-parent family, the blended family, and the multi-generational household, rather than the

traditional, intact nuclear family. Rather than defining the intact nuclear family as the only model of family health, we must create images and models that portray non-traditional, but healthy, family relationships.

- **Family/Social Network Assessment:** As experience within project SAFE sites has accumulated, the need for a more rigorous assessment of the family and social network of each woman has become increasingly clear. Lifestyle changes within this network—and the failure to make such changes—are often the critical ingredients in treatment success or failure. As Project SAFE continues to evolve, it will be helpful to capture and transmit across the various sites the tools and techniques that are developed to assess sources of support and/or sabotage in the SAFE mother’s family and social network.
- **Intimate Relationships:** There is some diversity in the patterns of intimate relationships presented by women served through Project SAFE, but a dominant pattern is seen repeatedly across most service sites. This includes a propensity for involvement in relationships that reinforce pathology rather than health. The relationships may be marked by shared addiction. The partners may be physically violent and abusive. Partners may be financially dependent upon the woman’s illegal drug-related activities. There may even be past and current incidents of coerced drug use in which the woman is manipulated into drug use under the threat of violence or abandonment. In short, there often exists a pattern of toxic, self-defeating intimate relationships that helps fuel and sustain the addictive lifestyle for Project SAFE women. These pathology-bonded relationships must be confronted in the treatment process, but this must be done in a way that protects the client’s physical safety.

While the ability to neutralize efforts at treatment sabotage by husbands or paramours is often the most critical early stage treatment task, intimate relationship issues continue throughout the treatment process. Addressing the status of toxic intimate relationships is often inseparable from addressing toxic relationships with alcohol and drugs. While much of this work focuses on issues of family-of-origin abuse and self-esteem for the client, efforts are also made to involve intimate partners in the treatment process. Some interventions have resulted in paramours' seeking treatment while the woman is involved in Project SAFE. Other intimate partners have been linked to self-help structures. Given the large number of women in Project SAFE who are involved with alcohol- or drug-dependent spouses or paramours, the inclusion of Al-Anon in the treatment milieu is important, not only for family members, but also for clients. For many Project SAFE clients, issues of addiction and co-dependency are inseparable.

- **Rebuilding the Nuclear Family Unit:** Project SAFE has pioneered a number of innovations for chemically dependent women, and the voices are growing that call for a separate educational and treatment track for the children of SAFE mothers. Addressing the needs of the respective units of a family does not automatically generate a healthy family system. If we create one track for the healing and development of the SAFE mother and a separate track for her children, when do the tracks come back together to reconstruct a healthy family unit? This question suggests that as we address the specialized needs of children, we must also maintain a focus on the whole.

As SAFE evolves, it is quite likely that we will see the evolution of parallel recovery tracks for the mothers and for the children of Project SAFE. Project Joyous and SAFE Futures is an

example of this. It is also likely that there will be a need for specialized skills and active treatment processes designed to focus specifically on nurturing health in the mother's adult relationships, in the mother-child relationships, and in the child-child relationships within the family system. Culturally competent, gender-responsive, and recovery-knowledgeable family therapists may emerge as a specialty role within Project SAFE.

- **Addressing Family-of-Origin Relationships:** Relationships between a Project SAFE client and her family of origin (defined by bloodline and by choice/tradition) are often strained or severed by the time the client enters treatment. One role of the treatment team is to help the client assess the nature of these relationships. Some relationships constitute crucial areas of support, while others, particularly those with family members who are actively drug dependent, constitute sources of sabotage and the risk of relapse. With the strengthening or weakening of these relationships congruent with the goal of addiction recovery, the process of reconstructing the client's family and social world can begin.

Many of the healthiest family members have emotionally buried (and perhaps physically severed) their relationships with the client through a process of anger and anticipatory grief. Access to family education and family counseling can help these members process past violations of trust and rekindle hope in the recovery process. There is wide agreement that these family and extended family relationships can provide significant support for the recovery process if the right cultural media can be found to involve them in the treatment process of Project SAFE women.

There is also a strong need for family-oriented substance abuse education to aid the client in

understanding her own family experiences and to help the client's family members understand addiction and recovery. Given that almost three quarters of Project SAFE clients report parental alcoholism within their own families of origin, such education is essential as an issue in client treatment. Teaching clients about family dynamics and substance abuse should focus particularly on the impact of parental alcoholism on child development and how such experiences influence one's own adult personality characteristics, parenting behavior, and intimate adult relationships.

***The Structure of Family Involvement***

Project SAFE sites need to continue their experiments with the timing, scheduling, and location of family involvement to determine which logistical designs create the greatest involvement of family members. Given the special characteristics of SAFE clients, would family services and family issues be more appropriately addressed after rather than during primary treatment? Which would be more effective, intense education and

counseling during an intensive treatment period, or short modules spread over an extended period of time during early post-treatment recovery? Would the best site for family education be the treatment center or a local neighborhood institution, e.g., a church? Are there educational family services that might be delivered via the medium of outreach? We need to continue to explore such questions through our programming efforts, and to capture and transfer our collective experience back and forth across the Project SAFE sites.

Some have lauded Project SAFE for its ability to engage addicted women in a long-term recovery process. Others have lauded Project SAFE for improving the quality of life for children. In the future, Project SAFE may be best known for its ability, not only heal the injured mothers and children, but also to resurrect from the ashes of addiction a healthy family, a family grounded in the sobriety, safety, and security of all of its members.

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# APPENDIX A

## Why Gender-Specific, Family-focused Addiction Treatment? A Review of the Research Literature

### A.1 Addiction in Women

*The social, emotional, and economic conditions in women's lives provide the context in which chemical dependency develops and in which a woman and her family can recover.* –Finkelstein, 1993

*The existing treatment models used with women have largely been developed by and for men and continue to be refined on the basis of research largely conducted on male subjects. Little attention has been paid to any psychological and physiological differences between men and women, or the socio-political context of women's lives.* –Copeland, Hall, Didcott, and Biggs, 1993

*Women and children require services that relate to their lives as family and community members, are preventive in nature, and offer support on a long-term basis.* –Finkelstein, 1994

*The primary barriers to the provision of more women-oriented services are theoretical, administrative and structural, and also involve policy and funding decisions.* –Reed, 1987

*Women-oriented drug dependence treatment services are defined as those that (a) address women's treatment needs; (b) reduce barriers to recovery from drug dependence that are more likely to occur for women; (c) are delivered in a context compatible with women's styles and orientations and is safe from exploitation; and (d) take into account women's roles, socialization and relative status within the larger culture (Reed, 1987, p. 151).*

Alcohol- and other drug-related problems in women first appeared in the United States in tandem with the dramatic increase in per capita alcohol consumption between 1780 and 1830 and a parallel increase in opium and morphine consumption in the following decades (Rorabaugh, 1979; Musto, 1973). Public recognition of these problems sparked the American temperance movement, drug control legislation, and the creation of an elaborate network of inebriate homes, inebriate asylums and addiction cure institutes. More than 400 women were on the waiting list when the nation's first inebriate asylum opened in New York in 1864. Five years later, the first facility specializing in the treatment of alcohol and drug dependent women, the Martha Washington Home of Chicago, was opened (White, 1998).

The addiction medicine literature of the nineteenth century gave considerable attention to the special needs of addicted women, but this recognition was lost in the larger demise of the treatment system in the opening decades of the twentieth century. When the professional field of addiction treatment was reborn in the middle decades of the twentieth century, little attention was given to the needs of women until the mid-1970s and 1980s when the National Institute on Alcohol Abuse and Alcoholism and the National Institute on Drug Abuse began sponsoring research on women and earmarking funds specifically to meet the treatment needs of addicted women. In the last three decades of the twentieth century, an unprecedented amount of research has documented gender differences in etiology, patterns of use, onset, stages, obstacles to treatment, treatment needs, and pathways and styles of addiction recovery. This same research has explored the impact of alcohol and drug addiction on the family and has

evaluated addiction treatment approaches designed to enhance family functioning and parent-child relationships.

This appendix will provide a brief review of why there is a need for gender-specific, family-focused treatment models such as Project SAFE. Readers wishing to place this research and Project SAFE in historical context are encouraged to review *Defining Gender-specific Addiction Treatment Recovery: Historical Milestones* in Appendix C.

### Limits of Knowledge

Research on alcohol and drug-related problems in women remains in its infancy, despite significant advances of recent decades. Although the number of female alcoholics in the United States has been estimated at 5 million, a 1987 review of alcoholism research (Vannicelli, 1987) identified only 3,278 women who had been included in alcoholism research studies in the preceding 29 years! That same year, Harrison and Belille (1987) reviewed the published evaluations of alcoholism treatment and found that only eight percent of participants of these studies were women. The historical exclusion of women from such studies came on such grounds as the following rationale for their exclusion in a 1976 follow-up study of alcoholics.

*The 25 women were excluded because of the special problems women pose in long-range follow-up studies: they change their names at marriage, and divorce and remarriage are more prevalent among alcoholic women than among men; fewer women drive cars, and fewer of them are therefore listed with the State Motor Vehicle Bureau; their telephone numbers are more likely to be listed under their husbands' names. All of these factors compound the problems of locatability.*

(Hyman, 1976, pp. 614-615)

The good news is that the number and quality of studies of addiction and recovery among women are increasing. These studies are generating findings with significant implications for the design of intervention programs. What follows are highlights of research that has particular relevance to the design and operation of Project SAFE in Illinois.

### Consumption

Alcohol consumption among adult and adolescent women increased in the 1960s and 1970s and then stabilized following a brief increase in binge drinking, primarily among younger women (Gomberg, 1993; Thompson and Wilsnack, 1984). Drinking patterns of adolescent women pose multiple risks: among 12<sup>th</sup> grade students, 1.1 percent of females report daily drinking and 23.5 percent report drinking to intoxication (i.e., consumption of five or more drinks in one drinking session) at least once within the past month (Johnson, et. al., 2001), 5.8 percent of female high school seniors report driving after consuming 5 or more drinks, and 11.8 percent riding in a car with an intoxicated driver (Johnston, et. al., 1999).

Within the U.S. population 12 years of age and over, 13.5 percent of females and 28.3 percent of males report “binge drinking,”<sup>1</sup> while 2.7 percent of females and 8.7 percent of males report “heavy drinking.”<sup>2</sup> This gender discrepancy is most pronounced among those 26 and older, and decreases steadily as age

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<sup>1</sup> Binge drinking is defined here as the consumption of 5 or more drinks on the same occasion on at least one day in the past month.

<sup>2</sup> Heavy drinking is defined here as consumption of 5 or more drinks on the same occasion on at least five days within the past month. All “heavy drinkers” are also, by definition, “binge drinkers.”

declines. Within the same population, 5.0 percent of females and 7.7 percent of males report using an illicit drug at some point over the past month (SAMHSA, 2001b). Once again, the “gender gap” is most pronounced among those 26 and older, with rates becoming more similar as age declines (SAMHSA, 2001b). When the use of specific illicit drugs in the past year is considered, men are more likely than women to have used marijuana, cocaine and heroin, although this pattern does not apply to all age groups. Females between the ages of 12 and 17, for example, are more likely than males to have used cocaine and/or heroin (SAMHSA, 1997). With regard to the nonmedical (illicit) use of psychotherapeutic substances,<sup>3</sup> though, the rates of female use (1.7 percent) and male use (1.8 percent) are similar (SAMHSA, 2001). Women, however, consume the vast majority of legally prescribed psychotherapeutic substances. Specifically, women consume 60 percent of all prescribed tranquilizers, 71 percent of all antidepressants, and 80 percent of all amphetamines prescribed in the United States (Davis, 1990). Women far outnumber men in the number of drug-related emergency room admissions related to tranquilizers, non-narcotic analgesics, antidepressants, and sedatives (SAMHSA, 2001a).

Older women are more likely than younger women to consume only alcohol (Harrison and Belille, 1987) or to consume alcohol and prescription drugs. Younger women are more likely to combine alcohol and illicit drugs (Lex, 1994). A high percentage of alcoholics and addicts are also addicted to nicotine—a fact that dramatically elevates the morbidity and mortality of this group. Many females report weight management as a factor in the onset of smoking and a deterrent to quitting (Blume, 1992).

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<sup>3</sup> Psychotherapeutic substances include prescription sedatives, pain killers, antidepressants, stimulants

There are many promotional forces for AOD consumption among women. Since the early patent medicine days, the pharmaceutical industry has pitched its products directly to women and the physicians who prescribe to for them. Alcohol and tobacco advertisers have targeted women with special products and special appeals—appeals linking these products to beauty, wealth, social popularity, sophistication and, perhaps most offensively, with liberation (“You’ve come a long way, Baby!”) (Jacobson, Hacker, & Atkins, 1983).

### **Risk of Addiction**

There is a higher incidence of alcoholism in men than in women—a pattern probably influenced by multiple factors. The best current estimate of a sex ratio for alcoholism is 2:1 to 3:1 (male to female) (Goodwin, 1988; NIAAA, 1990). This preponderance of men can also be seen among those addicted to nicotine and those addicted to illicit drugs. Women make up a higher portion of those dependent upon prescribed psychoactive drugs.

Historically, the addictions field reported that men were more likely than women to inherit a predisposition to alcoholism (Goodwin, 1988). Some studies indicate that women may be at greater risk if they have alcoholic mothers, suggesting that the transmission of risk was sex-linked (Cloninger, 1981; Bohman, et al., 1981). This portrayal of a limited role of genetics in female alcoholism has been challenged by the largest twin study on the heritability of alcoholism which concluded that 50-61 percent of the risk of female alcoholism is genetically influenced (Kendler, et al., 1992)

Many addicted women present for treatment with multiple etiological factors including increased genetic risk indicated by a high

incidence of familial addiction; a history of physical and sexual abuse; a history of emotional deprivation, and anxiety and depression that make frequent mood alteration desirable; and affiliation with social groups which promote excessive drinking.

### **Onset of Addiction**

The onset of alcohol and cocaine addiction in women is much more likely to be associated with a particular life event than such onset for men (Curlee, 1969; Griffin, et al., 1989). Events frequently associated with the onset of female addiction include childbirth, breast removal, hysterectomy, family problems, divorce, or the loss of a parent, spouse, or child through death (Rathbone-McCuan & Roberds, 1980). Incest and rape have also been identified as common precipitants of alcohol and other drug problems among women (Volpe and Hamilton, 1982-83).

Women experience the onset of drinking problems at a later age than do men (Beckman and Amaro, 1986)

### **Patterns of Addiction**

There are many clinically relevant gender differences in alcohol and other drug addiction. The course of addiction in women is different than men in its symptomatology and is marked by a faster progression—the latter often referred to as “telescoping” (Smith and Cloninger, 1981). Such accelerated effects were first noted in women addicted to alcohol (Corrigan, 1980; Hessebrock, et al., 1985; Stabenau, 1984) who seemed to become physically addicted to alcohol more rapidly than did men (Spiegel, 1986). Later studies also discovered that women become addicted to heroin faster than do men (Hser, et al., 1990) and that women addicted to cocaine reported earlier onset of use, higher rates of daily cocaine use, higher risk methods of

cocaine ingestion (smoking or intravenous), more concurrent alcohol use, and earlier age of entry into treatment (Griffin et al., 1989; Wechsberg, et al., 1998; McCance-Katz, et al., 1999).

In spite of the severe medical consequences of alcoholism in women, women alcoholics consume less alcohol than do male alcoholics and report less daily drinking and binge drinking (Blume, 1992). The phases of alcoholism are less distinct (Lisansky, 1957) and the symptoms and stages of alcoholism differ somewhat for women. Some documented early stage symptoms for men constitute late stage symptoms for women (James, 1975). These patterns are also influenced by age. Women alcoholics begin drinking later than do alcoholic men and lose control over their drinking at a later age (Fort & Porterfield, 1961).

Addicted women are more likely than men to be using other drugs in conjunction with beverage alcohol. They frequently present patterns of multiple concurrent and/or sequential drug use (Edwards, 1985; Celentano and McQueen, 1984). Multiple drug use places women at a higher risk for cross-addiction, toxic drug interactions and fatal overdoses.

Women are more likely to drink secretly at home (JAMA, 1973). In a study of 603 alcoholic women, only 2 percent reported any significant drinking outside the home (Kirkpatrick, 1986). This may differ by social class, ethnicity, and sexual orientation.

### **Alcohol/Drug Metabolism**

There are many pronounced differences between men and women and their relationship to alcohol. Women reach higher peak blood alcohol levels than men even when weight differences are considered (Jones & Jones, 1976). This may be related to the fact

that women have lower mean body water volume than men (creating higher alcohol concentrations) and greater difficulties metabolizing alcohol (resulting from lower levels of the gastric alcohol dehydrogenase required in the metabolism of alcohol) (Lex, 1991; Blume, 1992). Blood alcohol levels for women vary across phases of the menstrual cycle. Women report becoming most intoxicated before onset of menstrual flow and least intoxicated immediately after onset. Such variation is minimized for women taking oral contraceptives (Jones & Jones, 1976; Sutker, 1982). The onset and intensity of binge drinking has also been linked to pre-menstrual distress (Belfer, et al., 1971; Rusell and Czarnecki, 1986).

Women develop alcohol-related physical problems faster than do men. Women develop many complications of alcoholism, i.e. liver disease (alcoholic hepatitis with and without cirrhosis), hypertension, anemia, gastrointestinal hemorrhage, and ulcers after shorter periods of drinking and at lower levels of alcohol intake than men (Gearhart, 1991; Gomberg, 1993). The increased risk of cirrhosis for women may be influenced by the effects of estrogen on liver functioning (Galambos, 1972). The risks for alcoholic cirrhosis and cancers of the head and neck are elevated for women who consume more than 2-5 drinks per day (Wilsnack, 1984).

Alcoholic women also often report chronic obstetrical and gynecological problems (Wilsnack, 1973). In studies to identify high risk indicators of female alcoholism, menstrual difficulties (cessation of menstruation, irregular menses, painful menstruation), chronic pelvic pain problems, infertility, and high incidence of unsuccessful pregnancies were included in the at-risk profile (Russell, et al., 1981; Busch et al., 1986). Chronic alcohol abuse and alcoholism are associated with both irregular menstrual cycles and early

menopause (Jones-Saunty, 1981). Women addicted to other drugs also report high rates of infertility, vaginal infections, miscarriage, and premature deliveries (Blume, 1990; March and Miller, 1985)

While the link between nicotine addiction and cancer for both men and women is widely known, less known is the link between alcohol consumption and cancer in women. As little as three drinks per week can increase a woman's risk of breast cancer by 50 percent (Schatzkin, 1987; Willet, 1987). The Third National Cancer Survey revealed that women have a greater risk for cancer associated with high volume alcohol intake than do men (Williams & Horn, 1977). This risk is further enhanced by reports which indicate that 70-90 percent of alcoholic women also smoke cigarettes (Goodwin, 1988). Lung cancer now surpasses breast cancer as a cause of death among women (Blume, 1992).

Alcoholic women have an increased vulnerability to osteoporosis due to poor nutrition and the ability of alcohol to interfere with the body's absorption of calcium (Saville, 1975).

Women who are involved in intravenous drug use (heroin, cocaine), have injection drug using partners, are involved in the sex industry, or trade sex for drugs are at high risk of HIV exposure. In a sample of largely middle-class cocaine addicts in treatment, 29.5 percent of the female clients indicated that they had traded sex for cocaine, and 57.7 percent said that they had dated someone in order to gain access to cocaine (Webber, 1991). Morningstar and Chitwood (1987) surveyed a group of less affluent female cocaine addicts and found that 47 percent reported trading sex for cocaine. In addition to being at high risk for exposure to the HIV virus, injection drug users are at risk of numerous other medical complications, e.g., skin abscesses, cellulitis, serum hepatitis,

bacterial endocarditis, etc. The prevalence of AIDS is growing fastest among women, particularly poor women of color (Wechsberg, 1995), and considerable data exists indicating that women and men are less cautious and more likely to contract or pass on a sexually transmitted disease while under the influence of alcohol or other drugs (Goberg and Nirenberg, 1993).

Finally, there is the question of alcohol and drug-involved mortality data. Alcoholic women have higher mortality rates than either non-alcoholic women or alcoholic men (Hill, 1986). The death rate for female alcoholics is 50 percent to 100 percent greater than that for male alcoholics (Gomberg and Nirenberg, 1993). A mortality study of women living in St. Louis found that alcoholic women had 4.5 times the death rate of non-alcoholic women and that the average age of death for alcoholic women was 51 years compared to 66.5 years for non-alcoholic women. Primary causes of death for alcoholic women include diseases of the digestive and circulatory systems, accidents (particularly alcohol-sedative combinations), suicide and death by violence (Brenner, 1967; Lex, 1991).

The most significant clinical difference reflected in this data is that addicted women are much more likely than addicted men to present for treatment with acute or chronic medical disorders that require evaluation and treatment.

### **Ethnic Differences**

The characteristics and consequences of addiction are not consistent across ethnic groups. African-American women tend to be clustered at the extremes of abstinence and heavy drinking, with more Black women totally abstaining than White women (Gary and Gary, 1985). Patterns of illicit drug use also vary by race. African-American females

tend to enter addiction treatment an average of 5 years younger than do White women (Amaro, et al., 1987). African-American and Hispanic women are disproportionately represented among women with AIDS (71 percent) (Hopkins, 1987). Studies comparing African-American women with other women in addiction treatment report that African-American women are more likely to be described by staff as more confused, ambivalent about treatment, emotionally distressed, fearful, and guarded than women of other ethnic groups. They are also reported to be younger, less educated, less likely to be married, more likely to be supported on welfare, and less likely to use aftercare services following treatment (Carroll et al., 1981; Gary and Gary, 1985). Bushway and Heiland (1995) have described how the frequent characterization of African-American women as resistant to treatment may actually be a difference in emotional style: "It appears that African-American women may be lead with anger and later find their sadness while Euro-American women may be more comfortable leading with sadness and discovering their anger." Gary and Gary (1985) have called for the involvement of addicted women in positive, natural community support systems, including the Black church.

Mexican-American women abstain from alcohol or drink moderately. While the pattern of alcohol abstinence has been consistently reported for immigrant women, there are more recent reports of moderate and heavy drinking by Mexican-American women born in the U.S. (Caetano, 1985; Gilbert, 1987). The cultural influences that have discouraged alcohol use in Hispanic women may be reduced as these women become more integrated into American society.

Native American women experience the highest proportion of alcohol deaths. The

alcoholic cirrhosis death rate for Native American women, ages 15-34, is 36 times the rate for White women; the rate for African-American women is 6 times the rate for White women (Malin, et al., 1978).

There is a marked absence of research and discussion within the addictions literature on the drug consumption patterns and problems of Asian women.

### **Sexual Orientation**

Studies of lesbian women have consistently noted an increased risk of alcoholism and other substance use disorders (Lewis, Saghir, & Robbins, 1982). Studies report about one third of Lesbians meet diagnostic criteria for alcohol dependence (Lewis, et al., 1982). In addition to those characteristics shared with other alcoholic women, lesbian women may drink to feel more comfortable as a lesbian or drink to sublimate culturally stigmatized sexual feelings. This risk for alcoholism among lesbian women may have been intensified by the central role of the bar in lesbian social life (McGirr, 1975; McNally, 1989). This higher incidence of alcohol problems has been linked to the marginalization and stigmatization of gay and lesbian people.

Lesbian women (and women with histories of assault or involvement in prostitution) often experience discomfort and ostracism in mixed-sex treatment environments and, as a result, are at risk for early disengagement from treatment (Copeland and Hall, 1992). On the positive side, specialized recovery support groups (gay and lesbian AA meetings) and treatment programs (e.g., Pride Institute) have emerged and become more widespread in the past fifteen years (Finnegan and McNally, 1988; Kominars, 1989; Bushway, 1991). A survey of 1,864 lesbians and gay men in Minnesota revealed that 28 percent belonged

to a recovery support group such as AA or NA (Northstar Project, 1991).

### **Addiction and Psychiatric CO-morbidity**

Where addicted men are more likely to experience co-morbid personality disorders, addicted women are more likely to experience co-morbid affective disorders (Wilsnack, Wilsnack and Klassen, 1984). Alcoholic women are consistently assessed to be more depressed and anxious than non-alcoholic women and alcoholic men. Addicted women are twice as likely to report major depression than addicted men (Wechsberg, et al., 1994). Many researchers have suggested self-medication of affective disorder as a hypothesis in the etiology of female alcohol and drug addiction (JAMA, 1973; Sclare, 1970). There is also a high co-occurrence of eating disorders (particularly bulimia) and substance use disorders (Katzman, et al., 1991; Holderness, et al., 1994). Addicted women show higher rates of prior psychiatric treatment and greater incidence of prior suicide attempts than do non-addicted women and alcoholic men (Curlee, 1970; Gomberg, 1989).

### **Victimization as an Etiological Factor**

The relationship between childhood sexual abuse and/or subsequent sexual trauma and the onset and course of other problems is a complex one. What is most clear is the inordinate over-representation of those with histories of sexual abuse and assault among women entering addiction treatment programs. Addicted women report much higher rates of childhood sexual abuse compared to non-addicted women (67 percent compared to 28 percent) (Blume, 1992; Forth-Finnegan, 1991, 1984; Rachel, 1985; Covington, 1986). Reports of childhood sexual abuse among addicted women seeking treatment often ranges from 75-90 percent (Rohsenow, Corbett

and Devine, 1988). The incidence of such reports jumps from 20 percent when spontaneously reported to more than 75 percent when systematically collected as part of the assessment process (Zweben, 1996). There may also be certain traumagenic factors related to the experience of sexual abuse that increase risks for subsequent substance use disorders and greater severity of such disorders (see discussion in Chapter Four).

Addicted women often present patterns of serial victimization—childhood sexual abuse followed by later episodes of physical and/or sexual assault (Miller, et al., 1989). A subgroup of alcoholic women is reported to be suffering from post-traumatic stress syndrome following a relationship with a violent partner. The self-medication hypothesis related to excessive alcohol consumption may also apply to these women as well (Haver, 1986). This hypothesis is strengthened by the work of Anderson and his colleagues (Anderson, et al. 2002), who have recently published findings indicating that recurrent sexual abuse may produce changes in a portion of the brain known as the cerebellar vermis that increase the risk of substance abuse.

What is clear is that these patterns of victimization significantly increase one's risk for a whole range of life problems. Addicted women with histories of sexual victimization have a higher incidence of health problems and health care utilization than do addicted women without such histories (Liebbschultz, Mulvey and Samet, 1997). The sexual victimization of addicted women is often clinically nested within a larger cluster of problems, including feelings of depression, worthlessness, and powerlessness; suicidal thoughts; toxic, abusive intimate relationships, impaired mother-child relationships, and environmental chaos (Gomberg, 1993). The sexual abuse of addicted women may contribute to many of the clinical issues often

noted in women's treatment programs: fear and distrust, shame and guilt, feelings of unworthiness; conflict about sex role identity; self-doubts about adequacy as a women; and sexual dysfunction (Wilsnack, 1973; Kirkpatrick, 1986). The preponderance of addicted women with a history of physical and sexual abuse suggests by itself the need for special approaches to their treatment (Skorine & Kovach, 1986).

## **A.2 The Treatment of Addicted Women**

### **Sexuality as a Treatment Issue**

There are many misconceptions about the sexuality of addicted women. In spite of the stigma-inducing perception of promiscuity among heavy-drinking women, large controlled studies have found no such relationship (Klassen and Wilsnack, 1986). There is a complex role between alcohol and drug use and sexual dysfunction.

Alcohol may play a role in both alleviating and compounding sexual dysfunction in alcoholic women (Covington, 1985). Mechanisms through which alcohol abuse impairs sexual functioning include the acute depressant effects of alcohol on physiological sexual arousal; disruption of sex hormone metabolism as a result of liver damage; interference with sensory pathways of sexual arousal by alcohol induced neuropathy; organic brain syndrome resulting in decrease in interpersonal and sexual interest; and various medical problems secondary to alcoholism that negatively effect sexual functioning (Covington, 1986).

Many addicted women in treatment face the need to sort out feelings related to their sexual orientation. Covington (1986) reports a study in which six percent of addicted women self-identified themselves as lesbian while the percentage of these same women self-identifying themselves as lesbian once they

were in recovery jumped to 17 percent. She suggests that alcohol may assist some women in denying their physical and emotional attraction to other women.

Finally, some addicted women may need to address the issue of “skeezing” (i.e., sexual bartering for drugs). In a sample of largely middle-class cocaine addicts in treatment, 29.5 percent of the female clients indicated that they had traded sex for cocaine, and 57.7 percent said that they had dated someone in order to gain access to the drug (Webber, 1991). Morningstar and Chitwood (1987) surveyed a group of less affluent female cocaine addicts and found that 47 percent reported trading sex for cocaine. Such behavior may produce strong feelings of guilt, shame and low self-esteem in female addicts.

### **Treatment Admission Rates**

Women have lower admission and completion rates than men (Beckman and Amaro, 1984; Cuskey and Wathey, 1982; Nelson-Zlupko, 1995) and enter addiction treatment at more advanced stages of addiction than do men (Weisner and Schmidt, 1992). While one out of three alcoholics is a woman, only one of 20 is in treatment in any given year. Nationwide treatment surveys reveal that only 24 percent of alcoholism treatment admissions and 33 percent of drug abuse treatment admissions are women (Engs, 1990). In 1998, male admissions to publicly-funded substance abuse treatment programs outnumbered women by a ratio of 2.3:1 (SAMHSA, 2001c).

Women with substance-related problems are more likely to seek help for these problems from primary health care and mental health service providers rather than from specialized addiction treatment providers (Reed, 1987; Weisner and Schmidt, 1992). Poor women, particularly poor women of color, are less likely to seek help from either physicians or specialty

addiction treatment (March and Miller, 1985).

### **Treatment Obstacles**

There are many obstacles to entering and completing treatment that women are more likely to experience than men. These obstacles include:

- social stigma attached to addicted women, particularly addicted mothers (Gomberg, 1988),
- culturally ingrained female role characteristics, learned helplessness, passivity (NIAAA, 1983),
- multiple role responsibilities (Schliebner, 1994),
- inadequate financial or health insurance resources (Burman, 1992),
- fear of loss of custody of children and legal punishment (for pregnant, addicted mothers) (Finkelstein and Derman, 1991; Finkelstein, 1994),
- inadequate child care, transportation and sober housing (Owen, 1980),
- family enabling (protecting the alcoholic woman from the consequences of her drinking) (Beckman, 1984) or family discouragement for entering treatment (20 percent for women versus 2 percent for men) (Wilsnack, 1991),
- lack of comprehensive services, and
- discomfort with male oriented treatment philosophies and approaches (Blume, 1992).

The provision of specialized services such as child care, family counseling, and women's support groups are positively associated with more successful completion and outcome rates (Marsh, et al., 1986; Beckman, 1984).

Several authors have noted that current intervention theory which capitalizes on the family and the workplace as a motivating force for treatment may be inapplicable for a large number of addicted women who are not in the

workplace, and either have no significant family relationships or have relationships that constitute more a barrier than a source of support for treatment admission (Robinson, 1984).

There are also certain characteristics associated with early drop-out of treatment. These include a history of prostitution, legally coerced admission, and parents who have a history of addiction or psychiatric illness (Moise, Reed and Conell, 1981).

### **Treatment Entry Decisions**

The entry of addicted women into treatment is associated with 1) perception of alcohol or drugs as a problem, 2) life events (consequences) that precipitate a crisis and need for change, 3) the anticipation or experience of hope that treatment can produce positive change, 4) the perception that the treatment agency has programs that can respond to her special needs and the needs of her family, and 5) a social network that supports entry and continued involvement in treatment (Thom, 1984).

Admissions of women to treatment are more likely to be linked to health or family concerns (pregnancy, effect of use on children) than the occupational or legal issues that tend to bring men to treatment (Blume, 1992). Pregnancy and/or concern about parental adequacy are major motivators for women seeking entry into addiction treatment (Rosenbaum and Murphy, 1990)

Historically, addicted women have been more likely than addicted men to be involved in civil rather than criminal proceedings (divorce, custody) and to seek treatment related to such issues, but the number of women arrested on drug-related charges increased dramatically between 1986 and 1991, as did incarceration rates - there was a 241 percent increase for

White women, a 328 percent for Hispanic women, and a 828 percent for African-American women (Chavkin, 2001). The percentage of all female prisoners serving sentences on drug-related charges increased from 12 percent to 33 percent during these years (Snell and Morton, 1991). Younger women are more likely to report legal coercion into treatment than older women (Harrison and Belille, 1987).

Given the increased prevalence of health-related problems experienced by addicted women, it should not be surprising that a deterioration in physical health and concomitant fear of dying often serve as precipitating factors for entry into treatment (Wells, 1986).

There have also been new strategies, particularly the use of indigenous outreach workers, that have proved effective in engaging women in addiction treatment who previously resisted seeking out such services (Wiebel, et al., 1990; Groos and Brown, 1993).

### **Treatment Process**

The multiplicity of problems that characterized the lives of addicted women require a redesign of traditional addiction treatment.

Assessment instruments and processes for addicted women need to be global as opposed to categorical and continuing rather than an intake activity (Wechsberg, 1995). The treatment itself needs to focus on the whole spectrum of problems presented by the addicted woman rather than focusing narrowly on the problem of addiction (Brown, Huba, and Melchior, 1995; Wechsberg, 1995). The nature and number of these problems may dictate a longer period of indicated treatment for women. For example, time and physical healing may be required for alcoholic women to recover from alcohol-induced neuropsychological deficits before intensive

psychotherapies can be used effectively (Hill, in Wilsnack, 1984).

Traditional confrontational approaches in addiction treatment may be highly inappropriate and even injurious for many addicted women (Murray, 1989; Nelson-Zlupco, 1995; Zweben, 1996). As Beth Glover Reed has noted: "Tactics that are used early in treatment, which were developed to help men face what they have long denied, may cause women with learned helplessness patterns to feel even more hopeless and out of control" (Reed, 1987, p. 155). Such traditional approaches require substantial modification for clinical appropriateness and effectiveness (Brown, et al., 1996).

Motivational enhancement strategies offer a tested alternative to such clinical tactics (Miller and Rollnick, 1991). Poor self-esteem, learned helplessness, passivity, and dependence are significant treatment issues for alcoholic women. Recovery from alcoholism often involves balancing independence and dependence, developing increased skills of self-reliance and self-responsibility, and developing a new identity as a woman (NIAAA, 1983). This is particularly important in light of the fact that addicted women have less education and fewer marketable skills than do non-addicted women and addicted men (Hagan, 1987) and tend to be less active and involved in mixed gender addiction treatment groups (Lockheed & Hall, 1976).

### **Treatment Outcomes**

In spite of the popular conception (myth) that women are hard to treat and have poor treatment outcomes, available research data suggest that women do as well as or better than men in addiction treatment (Vannicelli, 1984). Some studies have even found that women have better post-treatment recovery outcomes (Rounsaville et al., 1982). In the

earliest review of gender differences in treatment outcome, Annis and Liban (1980) found, in a review of 23 studies, that women and men had similar outcomes in 65 percent of the studies; women had better outcomes in 22 percent of the studies and men had better outcomes in 13 percent of the studies—outcomes quite similar to a later review conducted by Toneatto et al (1992). In the Toneatto review, 60 percent of studies reported no gender differences in outcome; more than one third (36 percent) reported better outcomes for women, and four percent found better outcomes for men. In a study of cocaine treatment outcomes, McCance-Katz, Carroll and Rounsaville (1999) found that cocaine addicted women had longer periods of abstinence and reduced rates of continued drug dependence at follow-up from treatment than did male cocaine addicts. Studies of women-only versus gender-mixed treatment programs have produced conflicting results, with some gender-specific programs showing enhanced outcomes (Dahlgren and Willander, 1989), while others revealed no difference in outcome (Copeland et al., 1993). There is evidence that women-only treatment programs are able to reach those women that otherwise would not seek or complete addiction treatment (Reed and Leibson, 1981).

Poor treatment outcomes for women have been associated with: 1) presence of a disturbed or violent parent during childhood, 2) alcohol abuse and violence in partner at time of follow-up, 3) a repetitive pattern of violent partners following treatment, 4) removal of children from home by authorities during follow-up period, and 5) problems handling aggressive impulses (Hover, 1986; Hover, 1987; Bergman, 1985).

Involvement with an addicted partner is a major etiological factor in the onset of excessive alcohol and drug use for women and a major barrier preventing the addicted woman

from entering treatment or sabotaging her ongoing recovery efforts (Lex, 1994). It should not be surprising, then that unmarried women have better post-treatment recovery rates than those who are married (McCrary and Raytek, 1993)

Involvement in methadone treatment has been shown to provide structure and stability to the opiate-addicted woman, but that many women express concerns about the continued stigma of addiction related to their continued use of methadone (Rosenbaum and Murphy, 1990).

### **A.3 Recovery in Women**

#### **Processes and Stages of Recovery**

Women develop alcohol problems at a later age than do men and resolve these problems earlier. Two points are important here: the duration of alcohol- and drug-related problems and the prospects of recovery.

First, women have shorter alcoholism careers. Fillmore (1987) found that heavy drinking for women peaked in their thirties and then dropped sharply during their forties and beyond, with a substantial number of women ceasing alcohol consumption after age 60. In this same survey, daily drinking and drinking more than five drinks per drinking occasion were rare for women and almost non-existent after age 60. Fillmore concluded that in comparison to men, onset of heavy drinking occurs later for women, the duration of heavy drinking is shorter and remission of heavy drinking is more likely and more likely to occur earlier. In a subsequent study, Fillmore and her colleagues (1988) suggested that this age-related maturing out may differ among Blacks and Hispanics who are more likely to develop alcohol problems later in life.

Second, there is at least some evidence that women have greater prospects for long term

recovery than do men. Humphreys and his colleagues found in a follow-up study of clients eight years post-discharge that women were 1.63 times more likely to be in stable recovery (Humphreys et al., 1997). Mohr, et al., (2001) attributes these enhanced outcomes to the fact that alcoholic women entering treatment have more non-drinking friends who are supportive of their recovery process than do alcoholic men.

The greater prospects of recovery may also extend to women addicted to drugs other than alcohol. Snow (1973) reported that women addicted to opiates had better long term recovery rates than men similarly addicted.

#### **Recovery without Treatment/Moderated Recovery**

Many young women aged 21-34, who as a group report the highest incidence of alcohol-related problems, will resolve these problems without treatment (Wilsnack, 1989). Such “natural recovery” (the achievement of recovery from addiction without the aid of professionally-directed treatment or sustained involvement in mutual aid groups) is more common in women than in men.

In a recent study of natural recovery in women, Copeland (1998) found three themes in the resolution for change decisions: 1) concern for current and future health, 2) a lost sense of self, and 3) concern over the welfare of their children. Within these themes were found such gender-specific motivating factors as pregnancy, lactation, and fear of either victimization or high risk sexual behavior if addiction continued. Strategies that women use to self-manage their own recovery process include management of withdrawal, short-term drug substitution, severing drug-dominated intimate and social relationships, developing new social activities and relationships, and the cultivation of new health-promoting behaviors,

e.g., nutrition, fitness, alternative medicine (Copeland, 1998). Those women who cannot achieve natural recovery when compared to those who do are found to have greater problem severity, greater psychiatric comorbidity, and less family and social supports.

Gender differences are also noted in the literature about persons with alcohol problems who resolve such problems through moderating their use rather than by complete abstinence. Sanchez-Craig and her colleagues (1984, 1991) and others (Miller and Joyce, 1979; Elal-Lawrence, et al., 1986; Helzer, et al., 1985) have noted that women more likely than men to achieve successful moderation outcomes.

Again, this may be related to the Mohr study (2001) findings that women had richer non-drinking social relationships than men and that such relationships enhanced not only successful abstinence but also served to lower the number of drinks per drinking day among those who did drink.

### **Gender-specific Factors in Recovery**

There is growing evidence for gender-specific factors related to the initiation of recovery (e.g., pregnancy) and in obstacles to successful recovery (e.g., intimate involvement with an addicted husband or partner) (Anglin, et al., 1987). Chen and Kandel (1998) found that pregnancy and parenthood were the two most significant factors in cessation of marijuana use by women. Another factor related to the initiation of recovery in women is the fear of losing custody of their children (Burman, 1997). Waldorf (1983) found women separating from addicted husbands/paramours (often subsequent to their arrest) as a major factor in initiation of natural recovery in addicted women. Similarly, Wilsnack and her colleagues (1991) found divorce or separation associated with improved post-treatment

outcomes among treated, married women (Wilsnack, et al., 1991).

### **Developmental Stages of Recovery**

Recovery for most addicted women is a time-involved, developmental process. Stages of change that mark this recovery process include pre-contemplation (no readiness for change), contemplation (changes in awareness and perceptions but not behavior), preparation (planning for change), action (initiating sobriety), and maintenance (Prochaska, DiClemente and Norcross, 1992). A developmental model of recovery for women involved in Project SAFE in Illinois is included in the Appendix. This study detailed the complex change processes that marked addiction recovery in women who suffer from multiple problems and multiple barriers to recovery. Confirming these observations was a recent study (Brown, et al., 2000) concluding that women may be at different stages of change for different problems, e.g., substance use, high risk sexual behaviors, violent relationships, child neglect, and that such change processes must be simultaneously managed. For example, women with histories of trauma and symptoms of posttraumatic stress experience more anxiety and depression during early recovery (Bollerud, 1990), requiring what might be considered parallel recovery processes.

Relapse is also a part of the early recovery process for many women. Such relapse can involve the primary drug to which the women was addicted or the use of secondary drugs during recovery. Willie (1978) reported that recovered heroin addicts used drugs such as alcohol and cannabis in the first year to cope with the challenges of early recovery. Willie framed such use not as substitute addiction but as an “intermediary stage” of recovery. Similar findings occurred in Copeland’s (1998) study of natural recovery in women. All of the

women noted to have developed an initial problem with a substituted drug later resolved this problem. Early episodes of relapse and drug substitution are best seen as part of the recovery process requiring active management than an indicator of either the untreatability of the client or the failure of a particular treatment method.

### **Recovery Support Structures**

Alcoholics Anonymous is the most widely used community resource for the resolution of alcohol-related problems (Room, 1989) and Narcotics Anonymous has become a similar support structure for those addiction to drugs other than alcohol (White, 1998). Mutual aid involvement can play a significant role in the movement from addiction to recovery (Timko, et al., 1994; Devine et al., 1999; Fiorentine, 1999; Fiorentine and Hillhouse, 2000; Timko & Moos, 1999; McCrady & Miller, 1993; Emrick, et al., 1993; Tucker et al., 1994; Morgenstern, et al., 1997).

Women and cultural minorities affiliate with AA/NA at the same rates as White men (Humphreys, et al., 1994) and at least one report suggests that women may have an easier time affiliating with 12-step groups than do men (Denzin, 1987). This may be related to the fact that alcoholic women are more socially isolated (tell fewer individuals about their drug-related problems) and have less support from their partners for recovery (Bischof, et al., 2000). The percentage of women among AA members has increased from 15 percent in 1955 to 33 percent in 1996 (White, 1998). Special women's groups within AA grew during these same years. There are several feminist-based alternatives to AA (Kirkpatrick, 1976; Kasl, 1992), and AA's steps have been refined for greater applicability for women (Kasl, 1992; Lerner, 1990). There is also evidence that women, particularly African-American women, may

use the church as a sobriety-based support structure, a point that will be discussed in Chapter Four.

## **A.4 Substance Use Disorders and Child Maltreatment**

### **Addiction and Child Abuse/Neglect**

One of the historical problems in examining the link between alcohol and other drug use and the neglect or maltreatment of children and other family members is the existence of widely varying definitions of substance use, abuse and dependency, alcohol and other drug problems, addiction, child neglect, child abuse, and domestic violence (Leonard & Blane, 1992). It is difficult to address the linkage between two behaviors if one or both of them is ill defined.

*Parental substance abuse is among the factors that have fueled the rising number of abuse and neglect reports and has contributed to the rising number of children in foster care. It remains a key barrier to reunification for many of the children who reside in foster care for extended periods (DHHS, 1999).*

Although abundant research indicates that there can be a close association between parental alcohol and other drug abuse and child maltreatment (CWLA, 1992; Young, et al., 1998; DHHS, 1999) the precise nature of that association remains unclear.

Data from the 1996 National Household Survey on Drug Abuse indicates that as many as 8.3 million children (11 percent of the child population of the United States) live in households in which one or both parents have a serious alcohol or other drug problem (DHHS, 1999). The vast majority of these parents abuse alcohol, since the number of binge drinkers in the U.S. outnumber cocaine

addicts by 21:1, and heroin addicts by 98:1 (SAMHSA, 1998). In many cases, however, both alcohol and other drugs are abused within the home, making it difficult to separate one problem from another. 3.8 million children under the age of 18 live with at least one parent who is alcoholic, 2.1 million live with a parent whose primary problem is with illicit drugs, and 2.4 million children live with a parent that abuses both alcohol and illicit drugs (DHHS, 1999). Although it is often prenatally-exposed infants or younger children who are identified as coming from families in which there is a substance abuse problem, as indicated in Table 1, children who are part of a substance-affected family are distributed throughout the range of ages from 0-17.

**Table 1: Number of children who live with one of more parents who have a serious alcohol or other drug abuse problem, by age of child**

Age Range	Number Living with Parental Addiction
Under 2	0.9 million
2-5	2.1 million
6-9	2.1 million
10-13	1.6 million
14-17	1.6 million

*Source: Huang, et. al., 1998 based on the 1996 National Household Survey on Drug Abuse*

Across the literature, most studies report that between one-third and two-thirds of substantiated child maltreatment cases involved parental substance use. In a 1998 study conducted by the Child Welfare League of America, it was found that 50 percent of substantiated cases of child abuse or neglect

involved the use of alcohol or other drugs by one or both parents, and that 80 percent of the states report that poverty and substance use are the two main factors contributing to child maltreatment within their borders (CWLA, 1998). The Indian Child Welfare Association reports that 90 percent of Native American neglect cases and 60 percent of abuse cases are related to the use of alcohol or other drugs within the home (Cross, 1997).

Within Illinois, a OASA/DCFS needs assessment found that more than half of DCFS-involved parents identified substance abuse problems as their primary reason for contact with the Department (IDCFS, 1999). Further, a recent survey of child welfare workers in Illinois found that almost three-quarters of service plans included a requirement for addressing parental substance abuse problems (IDCFS, 1999). In one of the few prospective studies on children of addicted (alcohol and opiates) parents and child maltreatment, Black and Mayer (1980) found that nearly all children who live with alcohol or opiate addiction suffered some degree of neglect, and that almost one-third of the children sustained serious neglect. This study also determined that 22.5 percent of the children had been physically or sexually abused. When abuse and neglect were combined, 41 percent of the children were found to have been maltreated. No difference in the frequency of abuse or neglect was found between families in which alcohol was the drug of choice versus those who used opiates. These data are in contrast to rates of child abuse and neglect within the general population of the United States, which have been found to be 1.1 percent for abuse and 1.3 percent for neglect (DHHS, 1996).

In general, children with open child welfare cases whose parents have a substance use disorder are younger than other children in the child welfare system, more likely to have been

the victim of severe and chronic neglect, and are more likely to be placed in foster care rather than being served in the home. Once in foster care, such children tend to remain there for longer periods of time, and are more likely than other children to be adopted rather than returned to their family of origin (DHHS, 1999). In addition, children who are reared in homes where substance abuse occurs demonstrate more adjustment problems as well as more behavioral, conduct and attention-deficit disorders than other children. They also score lower than other children on measures of behavioral and emotional functioning (Johnson & Leff, 1999). It has also been noted that children in substance-affected families often suffer from a wide range of other problems, including mental illness, domestic violence, poverty, unstable housing, and dangerous neighborhood environments (Semidei, Radel & Nolan, 2001).

An additional issue related to the issue of child maltreatment and substance use disorders is the question of whether child abuse and/or neglect act as a precursor to adolescent and adult AOD problems. That is, are children who are abused or neglected at greater risk of becoming substance abusers than their non-maltreated peers? The answer to this question has great implications for both the prevention and child welfare fields, but is, unfortunately, difficult to answer with any precision. The high incidence of childhood neglect and victimization among addicts raise concerns that developmental deprivation and trauma constitute strong risk factors for subsequent development of substance-related problems.

### **Family of Origin History**

To adequately explore the relationship between maternal addiction to alcohol and/or other drugs and the neglect and/or abuse of children requires examining the family of origin experiences of addicted women, the

nature of their adult intimate relationships, and the nature of mother-child relationships before and during addiction as well as through the stages of addiction recovery.

Much of what each human being brings to life by way of identity, self-esteem, and degree of emotional health springs from experiences in his or her family of origin. These same experiences also influence the nature of our adult relationship choices and our relationships with our own children. In examining the professional literature, we find the nature and quality of early family life substantially different between women with and without addiction histories. Alcohol and drug-addicted women are more likely to report having had a disturbed childhood (Sclare, 1970), and to have exhibited symptoms of such disturbance (tantrums, enuresis, running away, school difficulties) (Gomberg, 1989a). Addicted women are more likely than women who do not experience addiction to have had parents who were either addicted or suffering from psychiatric illness (Winokur & Clayton, 1968; Forth-Finegan, 1991; Blume, 1986; Midanik, 1983).

Viewed as a whole, research on the family of origin experiences of addicted women may reveal that these women received increased genetic vulnerability for addiction to alcohol and other drugs, had primary experiences as children and adolescents within these families that further increased risk for behavioral health disorders, and often lacked role models for healthy intimate relationships and effective parenting.

### **Patterns of Marital/Intimate Relationships**

Alcoholic women are more likely to choose mates who are alcoholic or who suffer from psychiatric illness (Rimmer, 1974; Reed, 1985; Blume, 1992), just as women who use illicit drugs such as heroin and cocaine are

likely to have been introduced to and supplied these drugs by an addicted intimate partner with whom they are cohabitating at the time of admission to treatment (Kosten, Rounsaville, and Kleber, 1986; Eldred and Washington, 1976). Kirkpatrick (1986), in a survey of recovering alcoholic women, found 23 percent of those surveyed still married to actively drinking alcoholics. Alcoholic wives are much more likely to be abandoned by their husbands because of drinking; in contrast, wives of alcoholic men are much more likely to remain with their drinking husbands (Edwards, 1985).

Alcoholic women tend to select mates who come from family backgrounds similar to their own (Rimmer & Winokur, 1972). This process is referred to as “assortative mating” (Lex, 1991) and has been linked to the victimization histories of addicted women. The research literature on addicted women portrays a picture of unstable marital/intimate relationships characterized by low levels of emotional satisfaction and increased levels of marital conflict that can escalate into the emotional/physical abuse of the alcoholic woman. This picture must be viewed in the context of the high rate of victimization of these clients. Research has confirmed the propensity of traumatized women to “repeat and re-enact subordination and victimization in their interpersonal attachments” (Bollerud, 1990). Breaking these cycles of victimization requires specialized treatment approaches (Herman and Schatzow, 1984).

### **Substance Use and Partner Violence**

The association between substance use/dependency and domestic violence is highly intricate, involving factors related to 1) the effect of the drug, 2) the user’s personality and expectations of the drug, and 3) the social, legal and political environment in which the alcohol or other drug use takes place.

Among all psychoactive substances, alcohol is the drug the use of that is most often associated with domestic violence. However, the complexity of the relationship between the use of alcohol and domestic violence has been noted in numerous studies (Roizen, 1997; Fagan, 1993; Martin, 1992; Pernanen, 1991; Collins and Messerschmidt, 1993). On one hand, there is considerable scientific evidence that alcohol intoxication is often a factor in family violence:

- 30-70 percent of battered women report problem drinking or alcoholic drinking in their husbands (Fagan, Stewart & Hansen, 1983; Labell, 1979; Roy, 1982).
- Acute alcohol intoxication has been implicated in 50-70 percent of marital abuse incidents (Gaylord, 1975; Gelles, 1972; Nisonoff & Bitman, 1979; Pernanen, 1979).
- The number of men who batter their partners increases with the frequency with which they become intoxicated (Coleman & Straus, 1983).
- 40 percent of children reared in violent homes believe that their fathers had a drinking problem, and that they were more abusive when drinking (Roy, 1988).

The most popular explanation of this association is the disinhibition theory (Pernanen, 1981, 1991), which posits that alcohol impairs judgement and impulse restraint, leading to behavior which can be violent. This theory, which suggests that the batterer is "out of control" when he becomes violent, is challenged by other research finding that alcohol intoxication, per se, is often not linked to acts of domestic violence. For example, Kantor & Straus (1987) found that in three out of four episodes of domestic violence directed against women, neither the perpetrator nor the victim was intoxicated. It has also been reported that most men who are heavy drinkers do not abuse their intimate partners (Straus & Gelles, 1990).

Use of substances other than alcohol has been found in some studies to be more strongly correlated with domestic violence than is the use of alcohol (Roberts 1988, Kantor and Straus 1989), but, in fact, very little research has been conducted regarding the association between the use of illicit drugs and the occurrence of domestic violence. On a purely pharmacologic basis, there are abused substances that can, under the right circumstances, increase the potential for violence in some individuals. However, the majority of individuals who use these substances do not become violent. Research suggests that the most significant determinant of behavior following alcohol ingestion is not the pharmacological effect of the drug, but rather the user's expectation of the drinking experience (Marlatt & Rohsenow, 1980). It appears that the influence of alcohol on the potential for violence varies depending on who has been drinking, the context in which drinking occurs, the relationship between victim and perpetrator (Martin, 1993) and that factors other than the use of intoxicating substances need to be in place before domestic violence occurs.

Bennett and Williams (1999) have noted that "A man who drinks heavily does not have to be drinking in order to be affected by alcohol." In other words, men who drink heavily may have alcohol-related problems that increase the risk of domestic violence even in the absence of acute intoxication. Alcohol abuse and dependency are related to a wide variety of negative consequences, such as physical, psychological or economic problems as well as marital discord. Another of many possibilities is that some men who drink heavily may have a personality disorder (e.g., anti-social personality disorder) which also predisposes them to engage in violent behavior.

Regardless of the precise relationship between

alcohol and other drug use and domestic violence, the fact remains that intimate partner abuse is an important issue among women being treated for substance use disorders. Miller, Downs and Gondoli (1989) have noted that alcoholic women are more likely to experience violence within the context of their intimate relationships. In addition, women who are victims of domestic violence are more likely to misuse prescription drugs as well as alcohol (Stark & Flitcraft, 1988). Among women in addiction treatment, as many as 90 percent have been physically assaulted. Of these women, 70 percent reported that they had been victimized by their sexual partner or mate, with 74 being the mean number of incidents (Stevens & Arbiter, 1995).

Zubretsky & Digirolamo (1996) have argued that conceptualizing and addressing domestic violence from an addictions viewpoint are often based on assumptions that produce misguided, ineffective and potentially harmful interventions. These assumptions include:

1. Alcohol and other drug misuse causes men to batter.
2. If alcohol and other drug misuse is effectively treated, the threat of violence will disappear.
3. Most battered women are "co-dependent," contribute to the abuse cycle, and require treatment for their own pathology.
4. Addicted battered women must get sober before they can begin to address their victimization.

Currently, DHS is funding two demonstration sites in Illinois intended to enhance the working relationship between domestic violence service providers and substance abuse treatment program<sup>4</sup>.

### **Effects of Partner Violence on Children**

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<sup>4</sup> These model programs are located in Rockford and Belleville.

It is estimated that between 3.3 million (Carlson, 1984) and 10 million (Straus, 1991) children in the United States are at risk of witnessing acts of domestic violence (male perpetrator/female victim) each year. New research is sparking growing concern about the effects of pattern violence on children in the home:

*Violence in ones family has a wider variety of adverse outcomes than has heretofore been found. It seems reasonable to conclude that being a witness of violence between parents puts a child at risk of a number of serious mental health and other problems, and that this applies to children of all socioeconomic levels (Straus,1991).*

Research indicates that when children are witnesses to domestic violence, they may suffer the same effects and problems as those who are themselves physically or sexually abused (Goodman & Rosenberg, 1987). It has been observed that infants and young children are visibly upset by arguments between their parents, and that the occurrence of more serious forms of domestic violence may have serious implications for normal child development (Osofsky & Fenichel, 1994). The phenomenon of child observation of serious domestic violence has been termed “horrification” (Athens, 1992).

Pfouts, Schopler & Henley (1982) studied 25 children who had witnessed their mothers being abused. Within this group, 53 percent “acted out” with parents, 60 percent with siblings, 30 percent with peers, and 33 percent their teachers. In addition, 16 percent had appeared in juvenile court, 20 percent were identified as truant, and 58 percent were rated as below average or failing in school. Psychiatric symptoms were also noted; caseworkers reported that 40 percent were

anxious, and 48 percent suffered from depression.

Several studies have found that child witnesses exhibit more aggressive and antisocial as well as fearful and inhibited behaviors (Christopheropoulos et al., 1987; Jaffe, et al., 1986), display impaired social competence (Wolfe et al., 1986) as well as limited empathy and low self-esteem (Hinchey & Gavelek, 1982; Hughes, 1988). Sanders (1994) divided the problems exhibited by child witnesses to domestic violence into internalized problems (e.g., withdrawal, anxiety) and externalized problems (e.g., aggression, delinquency).

Children who witness domestic violence also suffer from an increased rate of physical problems. Kerouac, Taggaret, Lescop and Fortin (1986) found that children living in domestic violence shelters were almost twice as likely to be absent from school for health problems than children in the general population.

Since domestic violence is seldom a single event, but rather a pattern of behavior that escalates over time, it becomes increasingly likely that the child will eventually become a victim as well. A national study of 6,000 families found that 50 percent of the men who frequently assaulted their wives also physically abused their children (Straus & Gelles, 1990). McKay (1994) found that children from homes where domestic violence occurs are physically or sexually abused and/or seriously neglected at a rate 15 times the national average. There are also indications that when children are victimized both by witnessing domestic violence and being abused themselves, they often manifest more problem behaviors than those children who only witness violence in their homes (Hughes, Parkinson & Vargo, 1989). In this study, children who neither witnessed violence nor were victimized themselves had the lowest rate

of problem behaviors. There also exists the possibility that children who witness domestic violence may become batterers themselves as adults (Cappell & Heiner, 1990; Rosenbaum & O'Leary, 1981; Widom, 1989).

### **AOD Use Among Pregnant Women**

3.3 percent of pregnant women (ages 15-44) have used an illicit drug within the past month. This pattern is most pronounced among younger women, and use declines as age increases. Of those pregnant women 15-17 years old, 12.9 percent have used an illicit drug within the past month. Among those 18-25, this figure is 5.5 percent, and in the population 26-44, 2.1 percent (SAMHSA, 2001b). In addition, 19 percent of pregnant women have used tobacco in the past month, and 12.4 percent have used alcohol (SAMHSA, 2001). Of those women who drink during their pregnancy, 3.9 percent are classified as "binge drinkers" and 0.7 percent as "heavy drinkers" (SAMHSA, 2001).

### **Effects of Prenatal Alcohol/Drug Exposure**

Four substances--alcohol, heroin, cocaine and tobacco--have raised the greatest concerns regarding their effects on fetal development.

Since the pioneering work of Jones and colleagues (Jones, et al., 1973) at the University of Washington on what has become known as Fetal Alcoholism Syndrome (FAS), an extensive body of literature has evolved documenting predictable patterns of neonatal malformation associated with drinking during pregnancy. It has been further documented that such damage may be extended through continued exposure of the infant to alcohol passed via lactation during an extremely sensitive period of brain development. The major elements of FAS include:

- Low birth weight for gestational age

- Facial and cranial abnormalities
- Mental retardation
- Severely disturbed visual perception.
- Hyperactivity, distractibility, and
- Impaired short attention span.

In a follow-up study of the original babies studied by Jones and Smith, these researchers found severe developmental disabilities (IQs ranging from 20-57) in half of the children; the other half exhibited moderate disability or a low-normal range of intelligence.

Although rich documentation exists concerning FAS, the effect of illicit drug use on the outcome of pregnancy is more difficult to determine. Such challenges include multiple drug use, the adulteration of illicit drugs, sexually transmitted diseases and other health variables in the maternal and fetal environments, low socio-economic status, and poor maternal nutrition (Chasnoff, 1992; NIDA, 1999).

The long-term effects of in-utero exposure to opiates are not well-known (Jones, et al., 1994). Concern has been expressed within the literature regarding weak perceptual, visual and motor skills, impaired muscle tone. There is universal agreement within the medical community regarding the risk which preterm opiate withdrawal poses to the fetus. Abrupt withdrawal from opiates during the perinatal period is a risk factor for intrauterine fetal death (Jones, Smith, Martier, Dombrowski & Sokol, 1994). Detoxification from opiates during pregnancy carries with it the risk of spontaneous abortion and/or premature delivery. NIDA advises that pregnant, heroin-addicted women should not be detoxified from opiates, but rather maintained on methadone (NIDA, 2000). Although the newborn infants of methadone-maintained mothers are often born physically dependent on that drug, withdrawal can usually be safely and easily accomplished (NIDA, 2000).

More than any psychoactive substance other than alcohol, cocaine has been associated with the problem of prenatal drug exposure. The pattern of cocaine abuse which dominated the 1980s and 1990s gave rise to numerous studies which found that prenatally-exposed infants suffered from a wide variety of adverse neonatal effects, including:

- depression of interactive behavior and a poor organizational response to environmental stimuli (Chasnoff, Burns, Schnoll and Burns, 1985);
- intrauterine growth retardation and/or low birth weight (Zuckerman, et. al., 1989; Chiriboga, Burst, Bateman & Hauser, 1999; Snyder and Snyder-Keller, 2000; Behnke, Eyler, Garvan & Wobie, 2001);
- small head circumference (Eyler, Behnke, Conlon, Woods & Wobie, 1998; Chiriboga, Burst, Bateman & Hauser, 1999; Snyder and Snyder-Keller, 2000; Behnke, Eyler, Garvan & Wobie, 2001);
- cerebral and/or bowel infarction (Snyder and Snyder-Keller, 2000);
- genitourinary tract malformation (Chasnoff, Burns, Schnoll & Burns, 1985; Chasnoff, Chisum & Kaplan, 1988);
- cardiac, intestinal, renal and/or nervous system anomalies (Bingol, N, et. al., 1987; Chavez, Mulinare & Cordero, 1989); and
- limb reduction malformations (Chasnoff, Chisum & Kaplan, 1988; Hoyme, Jones & Dixon, 1989).

Beginning in the mid-1990s, some of these findings came into question. Slotkin (1998), for example, argued that nicotine use may have created many of the adverse perinatal effects attributed to cocaine. NIDA has also expressed concern that fetal exposure to cocaine may not be as devastating as once thought:

*Many may recall that "crack babies," or babies born to mothers who used cocaine while pregnant, were written off (by researchers) a decade ago as a lost*

*generation. They were predicted to suffer from severe, irreversible damage, including reduced intelligence and social skills. It was later found that this was a gross exaggeration. Most crack-exposed babies appear to recover quite well. However, the fact that most of these children appear normal should not be over-interpreted as a positive sign. Using sophisticated technologies, scientists are now finding that exposure to cocaine during fetal development may lead to subtle, but significant, deficits later, especially with behaviors that are crucial to success in the classroom, such as blocking out distractions and concentrating for long periods of time (NIDA, 1999).*

More recently, Frank and her colleagues (Frank, et. al., 2001) reviewed 74 papers from the medical literature (1984-October 2000) that discussed the effects of prenatal cocaine exposure on infants and children. They concluded that:

*Among children aged 6 years or younger, there is no convincing evidence that prenatal cocaine exposure is associated with developmental toxic effects that are different in severity, scope, or kind from the sequelae of multiple other risk factors. Many findings once thought to be specific effects of in utero cocaine exposure are correlated with other factors, including prenatal exposure to tobacco, marijuana, or alcohol, and the quality of the child's environment. Further replication is required of preliminary neurologic findings.*

In spite of this apparent reversal of professional opinion, there are continued reports (Smith, Chang, et. al., 2001) of metabolic abnormalities in the brains of children who were prenatally exposed to cocaine, and suggestions that such exposure

leads to impulse control problems and deficits in attending abilities.

The primary risk associated with tobacco use during pregnancy is intrauterine growth retardation and associated low birth weight. On average, infant birth weight is reduced by about 200 grams<sup>5</sup> ( Jones, Smith, Martier, Dombrowski & Sokol, 1994). While this reduction in weight may not be significant for the offspring of otherwise healthy women, it can be a serious problem for infants born to mothers who also suffer from poor nutrition, inadequate prenatal care, intrauterine infection, or other risk factors. With the exception of “congenital anomalies” (serious physical defects), low birth weight is the single most accurate predictor of infant mortality<sup>6</sup> (Centers for Disease Control, 2001).

The focus on the specific effects of one particular drug (alcohol, cocaine, heroin) obscures the fact that multiple drug use is the most common pattern of use by pregnant women and women of childbearing age (Finkelstein, 1993).

### **Special Needs of Pregnant Women**

Addicted, pregnant women experience enhanced barriers to treatment. These barriers are attitudinal (greater stigma), legal (threat of punishment), and structural (inadequate and highly fragmented service resources). These barriers are even greater for the opiate-addicted, pregnant woman. Finkelstein (1993) has called for the development of specialized services for addicted, pregnant women that are family-centered, community-based, multidisciplinary, competency-focused, comprehensive, collaborative, individualized and long-term in terms of their support

services.

What do we know about the nature and quality of the relationship that exists between the addicted mother and her child and, in particular, what, if any, is the predictable impact of maternal addiction on a child? Does such impact consistently include neglect or abuse?

As we examine literature from both the child welfare field and the addiction fields, certain cautions are in order. Literature from both fields tends to be long on personal testimonials and clinical description and short on carefully designed and controlled research. Like addiction, the etiology of abusing and neglectful behavior by parents is both complex and interactional.

In spite of the popular notion that pictures the addicted mother abusing her children, research does not support such a clear and direct relationship between alcoholism and the physical or sexual abuse of children by the alcoholic parent. The perception that alcoholism *per se* dictates or automatically creates a pattern of abuse is being increasingly questioned (Orme & Rimmer, 1981). Black and Mayer (1979) found that the majority of alcoholic parents did not physically or sexually abuse their children. The familial history of the alcoholic as a child may be a more important determinant of abusive behavior than the alcoholism. Schaeffer and colleagues (1985) found that chemically dependent women who were abused as children are more likely (than non-chemically dependent women similarly abused) to go on to physically or sexually abuse a child. It may be that the lowering of inhibitions and impairment of judgment and impulse control produced by alcohol intoxication may increase the probability of abusive behavior, but that the inclination for such abuse, which has been shaped by family history, may be the determining prerequisite

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<sup>5</sup> 200 grams is slightly less than one-half pound

<sup>6</sup> Infant mortality is defined as death before during the first year of life

for abusive behavior. In studies of abusive behavior, there is almost total unanimity in the following proposition: abusing parents were physically or emotionally abused or neglected as children.

Where addiction as a causal link to child abuse is unclear, the professional literature consistently describes patterns of neglect and deterioration in parental functioning produced by alcoholism and other addictions. For instance,

- The majority of alcoholic mothers in treatment self-report that their drinking interfered with the quality of their parenting (Corrigan, 1980).
- Children with two alcoholic parents experience the highest incidence of neglect and inconsistent discipline and contact with the parents (Williams, 1982).
- Discipline in the alcoholic home is described as lax and inconsistent, and management of children's behavior is more likely to be characterized by yelling and threats than by praise (Hindman, 1979).
- Roles in alcoholic families are often poorly defined, with children frequently taking on the responsibilities of their alcoholic parent (Seixas, 1977).
- Children of alcoholic parents are more likely to be threatened with or experience separation from parents. In two studies, over one-third of the children of alcoholic parents were removed from their homes by court order (Bourgeois, et al., 1975; Miller & Jang, 1977).
- Both Black (1979) and Booze-Allen and Hamilton (1974) report that the return of family health and parental functioning does not automatically occur with sobriety. In some of the cases they studied, it took years before the alcoholic parent could become a healthy role model. Improvement in parenting and family health may require more specific interventions than simply alcoholism treatment.

## A.5 Family Recovery

There is little research data on what happens within families when an addicted member enters and sustains recovery over time. There are virtually no such studies that focus on opiate or cocaine addiction and only one longitudinal study of family recovery from alcoholism. Brown and Lewis' (1994, 1999) study of family recovery from alcoholism challenges the idea that family health returns quickly following the achievement of stable sobriety. In studies of families in recovery over an extended period of time, they drew the following conclusions:

1. Adaptation to alcoholism distorts the development of individual family members and traumatizes the family as a whole. Aspects of this "unsafe, potentially out-of-control environment" continue for as long as three years into the initiation of sobriety and mastery of early recovery.
2. The unhealthy family system must collapse, allowing a shift in focus from maladaptive maintenance of alcoholism to the individual development of family members. In recovery, a family is taken apart, its individuals are healed and then the a new family is created from the healed elements. Individual recovery must precede family recovery.
3. Recovery does not automatically bring effective parenting: "...children may be just as neglected and abandoned in recovery as they were during the drinking, or more so, as the system collapses and parents turn their attention away from the family onto themselves" (Brown and Lewis, 1999, p. 23).
4. The challenge of recovery is how to pay attention to individual recovery needs while simultaneously responding to the evolving needs of children.
5. Families in recovery experience a difficult

process of change that can last as long as ten years before the final developmental goal—a healthy family system—is reached (Brown and Lewis, 1999).

Kirkpatrick (1986) has eloquently described the propensity for alcoholic mothers to overcompensate during early sobriety by beginning to overprotect, overdiscipline and overcontrol the lives of their children only to find that the children become rebellious in response.

### **Substance Use/Psychiatric Risk to Children of Addicted Women**

There is growing concern about the potential intergenerational transmission of alcohol and other drug problems. Children of alcoholics have 4-5 times the risk of developing alcoholism as an adult than the general population (Goodwin, 1988). Many authors have begun to outline how childhood experiences in the alcoholic family are carried into adulthood as enduring traits. Kritsberg (1985), for example, suggests that such effects include the following: shame and guilt, emotional numbness, compulsive and rigid patterns of thinking, indecisiveness, hypervigilance, sexual dysfunction, vulnerability for stress disorders, and problems with intimacy. These may reflect simply an extension of the descriptors of children who have grown up with parental addiction: distrustful, emotionally withdrawn, fearful, anxious about the future, cold, rigid, submissive, dependent, and angry.

### **A.6 Summary of Presenting Pattern**

Nationally, this prototype client is entering publicly funded treatment in her late twenties without a high school education or significant vocational experience and with a history of public assistance. Her family of origin is characterized by multigenerational patterns of

alcohol/drug problems and physical/sexual abuse. She is currently unmarried although likely to be involved in an abusive relationship. She has two or more children, some of whom are in the custody of a child welfare agency, others who are coming to the attention of public health, child welfare, school or juvenile justice authorities. At the point of admission she has co-occurring medical and psychiatric problems and numerous other problems requiring attention, e.g., homelessness or inadequate housing, lack of transportation, pending legal proceedings. When pregnant, the presenting needs are even more complex and compelling. She has a history of contact with multiple community agencies but no periods of sustained, stable personal or parental functioning (Uziel-Miller and Lyons, 2000).

### **A.7 Emerging Model**

In 1986, a sweeping review of the addiction treatment research concluded that there was little research evidence to support the efficacy of any particular treatment approaches for addicted women (Vannicelli, 1986). Since then, there has been an accumulation of research that has begun to define the major elements of an evidence-based, gender-specific and family focused model of addiction treatment. Women-specific addiction treatment programs differ significantly in the variety, comprehensiveness, design, duration and cost of services (Grella, et al., 1999). Gender-specific, family-focused addiction treatment programs are distinguished by the following:

- providing outreach services (Reed, 1987),
- focusing on addiction as one of multiple problems that requires a concentrated and sustained focus (Nichols, 1985; Wallen, 1992; Zweben, 1996),
- cultivating and maintaining relationships and a higher number of helping agencies and having a higher frequency of contact

- with such agencies (Reed, 1987),
- concentrating services, to the greatest extent possible, in a single, non-stigmatizing service environment (Kaplan-Sanoff and Leib, 1995; Finkelstein, 1993),
- linking addiction treatment services to primary health care for the mother and her children,
- focuses simultaneously on the needs of both the woman and her children,
- treating gynecological and medical problems (Burman, 1992),
- providing child care, transportation and housing services (Beckman and Amaro, 1986),
- linking clients to domestic violence services,
- assessing the needs of the whole family, including the needs of each child as part of the initial global assessment process.
- providing strong female role models both in terms of leadership and personal recovery (DiMatteo and Cesarini, 1986; Reed, 1987),
- providing all female groups and female therapists, outreach workers and case managers (Ruggels, et al., 1977),
- cultivating a nonhierarchical, partnership model of client-staff relationships (White and Chaney, 1993; Trinh, 1998),
- “reparenting” the recovering mother so that she may parent her own children (Kaplan-Sanoff and Leib, 1995),
- placing an emphasis on client empowerment via the goals of personal and economic self-sufficiency and an emphasis on choices throughout the treatment process (LaFave and Echols, 1998),
- addressing the shame and guilt associated with both alcoholism/addiction and child neglect and/or maltreatment,
- providing women-only, peer support groups within the treatment milieu (Woodhouse, 1990),
- encouraging sexual autonomy related to desires, preferences, and limits (Nelson-Zlupko, 1995),
- providing case management services to address personal and environmental obstacles to recovery,
- assuring physical and psychological safety within the treatment milieu,
- addressing issues of low self-esteem, learned helplessness, victimization, co-morbid disorders (particularly depression), and educational/vocational needs,
- training in parenting as well as women-specific concerns related to hygiene, birth control, STD prevention and treatment,
- giving admission priority and special treatment protocol for pregnant women,
- providing a longer duration of treatment involvement with a structured program of family-focused aftercare,
- the provision of pregnancy-related services.

In short, gender-specific, family centered treatment offers addicted women a large menu of treatment services and a high degree of support to keep her from getting overwhelmed with the sheer multitude of tasks involved in her recovery and that of her family. In this appendix, we have reviewed the research literature that calls for gender-specific, family focused treatment of addicted women with histories of neglect/abuse of their children. In Chapter One, we will describe how such a model came to be implemented in communities across Illinois, and how Illinois came to answer the most critical issue shared by addiction treatment and child welfare agencies: How can we best address the conflict between the short permanency planning guidelines in the child welfare field versus the reality of relapse for many clients and the sustained treatment and support services required by many clients to achieve addiction recovery (Finkelstein,1993).

## APPENDIX B

## **A Developmental Model of Recovery**

By William White, in collaboration with Maya Hennessey,  
Deborah Oberg and Diane Sonnevile  
(1990, edited by W.W. 2002)

Early Project SAFE reports raised a number of theoretical questions about the nature of addiction and recovery in women, and called for the construction of a research-grounded developmental model of recovery that could illuminate the styles and processes of addiction recovery among Project SAFE clients. In the absence of quantitative research data, stories and perceptions about stages in the recovery process for SAFE women were solicited from child welfare workers, outreach workers and treatment staff at all of the SAFE sites. This qualitative data was then organized into a beginning conceptualization of the stages of change experienced by most women involved in this project. This brief paper represents an attempt to provide a theoretical framework from which the recovery of Project SAFE women can be understood and from which interventions can be strategically selected and appropriately timed.

### ***Recovery as a Developmental Process***

There are a number of key propositions central to a developmental model of addiction recovery. Those most crucial to organizing the experience of women in Project SAFE include the following:

- Addiction recovery, like the active process of addiction, is often characterized by predictable stages and milestones.
- The movement through the stages of recovery is a time-dependent process.
- Within each stage of recovery are developmental tasks, skills to be mastered, certain perspectives to be developed, certain issues to be addressed, before movement to the next stage can occur.
- The nature of the developmental stages of recovery are shaped by the characteristics of the individual; the nature, intensity and duration of drug use; and the social milieu within which recovery occurs.
- Developmental stages of recovery, while highly similar within subpopulations of addicts, may differ widely from subpopulation to subpopulation.
- Treatment interventions must be strategically selected to resolve key issues and achieve mastery over key developmental tasks inherent within each individual's current stage of recovery.
- Treatment interventions appropriate to one stage of recovery may be ineffective or pose iatrogenic risks when utilized in another stage of recovery.

These propositions are consistent with the growing body of research on stages of change (Prochaska, et al., 1992).

What follows is not a developmental model of recovery for women. The proposal of such a model would imply that women experiencing substance use disorders present with gender-defined and gender-shared problems that are unaltered by other dimensions of individual

character and experience. Such a model would also imply that there is a shared developmental trajectory (a singular pathway) of recovery for all women and that there exists a narrowly proscribed treatment technology to provide guidance through this developmental process. What follows is a developmental model of recovery for *persons* who share certain experiences and characteristics. There are many women for whom this model would not apply and many men for whom it would. The fact that more women than men share the core characteristics defined below is a function not of gender biology but of the social, economic and political oppression within which women are born and within which they must seek their individual destinies.

### *The Core of Shared Experiences and Adaptations*

The developmental trajectory of addiction recovery is shaped by the totality of experiences each person brings to the recovery process and, in particular, what each person brings by way of “recovery capital.” Recovery capital is the total amount of internal and external resources a person can bring to bear on the initiation and maintenance of recovery (Granfield and Cloud, 1999). Populations for who share similar levels of recovery capital, similar assets and life experiences and circumstances, often share similar developmental processes of recovery.

Project SAFE women were often involved in a complex web of interlocking relationships (and problems) spanning several generations. The women who entered Project SAFE shared many experiences that shaped their perceptions of self, the self-drug relationship and the self-world relationship. It is impossible to understand the nature of addiction and recovery in these women without understanding the core experiences of their lives. Such core experiences include:

- Early and continuing losses
- Parental addiction and/or psychiatric illness
- Physical/sexual trauma
- Predatory social environments
- Recapitulation of family trauma in adult intimate relationships

When clinicians within Project SAFE compared the experience of SAFE women with the non-addicted women they had counseled who had not been involved in the abuse or neglect of their children, significant differences emerged. While women from both groups reported experiencing sexual abuse in childhood, the women of Project SAFE women reported an earlier age of onset of sexual abuse, multiple rather than single perpetrators of abuse, long duration of abuse (often measured in years), the presence or threat of physical violence as a dimension of the abuse, more boundary invasive forms of sexual abuse, and either being blamed or not believed when they broke silence about the abuse. What distinguishes Project SAFE women is not the occurrence of physical or sexual abuse or early childhood losses in their lives, events that many women experience, but the intensity and duration of these experiences.

Project SAFE clients tended to share both certain conditions and events in their lives and certain meanings attached to these experiences. The experiences catalogued above created shared beliefs about themselves and the outside world. These beliefs became mottos for living and a major barrier to recovery:

- I am unlovable; I am bad.
- There is no physical or psychological safety.
- If I get close to people, they will die or leave me.
- My body does not belong to me.
- I am not worthy of recovery.
- Everybody's on the make; no one can be trusted.

### *Dependency as the Core Developmental Dimension for SAFE Women*

In clinical staffings of Project SAFE women, the words “dependency, passivity, learned helplessness and learned hopelessness” were frequent refrains. It is our belief that shifts in this dependency dimension mark the essence of the developmental process of recovery for SAFE women.

In America, there is a deep paradox related to dependency. The culture highly values self-reliance and autonomy, but prescribes roles to women which inhibit self-assertion and encourage service and sacrifice to others. Women who most inculcate those values ascribed to women are branded as “pathologically dependent.” Women who challenge these values through self-assertion are often accused of somehow hurting their men, their children, their communities and their society. While most women experience some aspects of this cultural double-bind, some experience an intensified version of this self-dwarfing process. For the majority of women in Project SAFE, family of origin experiences began what became an escalating pattern of self-diminishing dependency upon people and things outside the self. Such patterns involve:

- An inability to state one's own wishes, needs, or ideas due to fear of conflict or rejection.
- A diminished capacity to define or assert one's own values and beliefs (to be self-directed).
- A severely diminished experience of self-legitimacy and self-value.
- An inability to pursue self-fulfilling, self-nurturing activities without fear and guilt.
- Achievement of esteem through identification with a person, group, or institution.
- A fear that life success or self accomplishment will be followed by punishment or abandonment.
- An inability to initiate action to resolve one's own problems.
- A programmed preference for passivity, withdrawal and helplessness when confronted by problems and challenges.

We do not view such dependency patterns as inherent in the biology or character of women. We view such patterns as flowing from self-obliterating family and cultural systems. They are survival adaptations. They are strategies of self-protection. They are defenses against physical and psychological assault. Self-defeating patterns of dependency are highly adaptive, and passivity can serve as an alternative protective device to challenging and confronting family or cultural rules. Passivity and dependence often serve as homeostatic mechanisms within a

marital/family system. Ego-sacrificing acts of women often serve to boost the egos of others. This dependency dimension influences the manner in which these women must be engaged in the change process. Interventions, such as traditional confrontation approaches that heighten guilt and inadequacy, are misguided and harmful for this population. The dependency dimension influences the changing role of the treatment program staff in the long-term recovery process. In the developmental stages outlined below, we have charted a progression from self-defeating dependence to healthy inter-dependence. The desirable and achievable goal of the change process extols not autonomy and self-reliance, but reciprocity and mutuality. This process is depicted as a movement from the denial and abuse of self to an affirmation of self within the context of mutually respectful intimate, family, and social relationships.

### *The Limitations of Stage Theory*

In 1969, Elizabeth Kubler-Ross published her now classic work *On Death and Dying* in which she described five stages of grief and mourning (denial, anger, bargaining, depression and acceptance). Many counselors have for years used this theoretical framework to assist them in working with grieving clients. Used appropriately, this theoretical model has helped many clinicians both understand and mediate the healing process involved in traumatic loss. Applied to restrictively, this theoretical model has been misapplied by some clinicians to program the grief experience of clients for whom alternative styles of healing may be more naturally appropriate. Similarly, stages of change theories have been very popular in the addiction treatment field in recent years. But we have also used such models used to exclude clients (defining “pre-contemplative” clients as inappropriate for admission to treatment) rather than to enhance their readiness for change.

Models, as metaphors of collective experience, can be tools of empowerment for both clinicians and clients, particularly when the model fully embraces the experiences and needs of both. When a model doesn't fit the experience and needs of the client, its application can result in unsuccessful treatment or harmful treatment.

The construction of a developmental model of recovery for women in Project SAFE is an important milestone in the evolution of this project. It provides the theoretical foundation for what works and doesn't work in our interventions with these women and their families. It provides the framework that vindicates our movement outside the traditional boundaries of traditional theories and techniques to meet the needs of these women. The developmental model of recovery which follows should, however, not be viewed as a road map of recovery for all women, nor should the stages outlined be utilized as a prescriptive recipe whose ingredients and preparation procedures must always be the same. Our model is a road map that has utility only when it precisely reflects the clinical terrain within which we are working. When this terrain changes via core characteristics and experiences of women in Project SAFE, then the model should be adapted or discarded.

In our observation of and involvement with Project SAFE women over the past sixteen years, we have seen six identifiable stages in the movement from addiction to stable recovery. These stages and the roles helping professionals can play in each stage are described briefly below. The stages are a composite of what we have seen with Project SAFE women. Some women skipped certain

stages. Others varied the sequence. Still others went through several cycles of these stages during their SAFE tenure. The stages overlap and there are not always clear points of demarcation separating one from the other. For example, early stage issues of safety and trust don't completely dissipate. They simply require less emotional effort as the ever-present roar of "don't trust" subsides to a whisper.

### **Stage 1: Toxic Dependencies**

If there is any phrase that captures the pre-treatment status of Project SAFE women, it is "toxic dependencies." They bring dependencies on alcohol, cocaine, heroin and other psychoactive drugs that have interfered with many areas of their lives. They exhibit a propensity to involve themselves in toxic, abusive relationships with men and women. They also exhibit a propensity to involve themselves in toxic relationships with "enabling institutions" whose effect is to sustain rather than break this larger pattern of dependency. The Project SAFE client has little sense of self outside these dependent relationships with chemicals, people and institutions.

The themes of death, loss, abandonment, and violation of trust in her life are constants that progressively diminish self-respect and self-esteem. Whether manipulated through nurturing or through violence, she has learned that the world is a predatory jungle in which physical and psychological safety is never assured. Out of self-protection, a secret self is created and encapsulated deep within this women. She protects and hides this self from exposure to outsiders. Her true self can never be rejected because it will never be revealed. Sealed in fear and anger, this secret self becomes so deeply hidden that the woman herself loses conscious awareness of its existence.

The locus of control during active addiction is increasingly of external origin. Her relationship with drugs cannot be internally controlled by acts of will or resolution. Her relationships with others are marked by inconsistency and unpredictability of contact. Everything in her life seems to be shaped by outside forces and persons. By the time a woman comes in contact with Project SAFE, the power to shape her own destiny has been obliterated by the chaos of her life. Her life is buffeted by the conflicting forces of her drugs, her drug using peers, her family, her intimate partner, and a growing number of social institutions closing in on her lifestyle.

Amidst this backdrop of chaos, she slides into increased passivity, increased hopelessness and helplessness and increased dependence on drugs and toxic relationships. There is pain in great abundance, but insufficient hope to fuel sustained self-assertion into recovery. "Powerlessness" for this woman is a fact of life, not a clinical breakthrough. The spark that can ignite the recovery process must come from without, not within. For social agencies to wait for this woman to "hit bottom," in the belief that increased pain will motivate change is delusional and criminal. Where the internal locus of control has been destroyed, the client can "live on the bottom," having lost everything short of her own life, and still not reach out for recovery. It is not a shortage of pain, but a shortage of hope and a lost capacity to act, that serve as the major obstacles to change. More potential sources of external control eventually emerge through crises related to homelessness, acute medical problems, arrest, victimization by violence, or through the abuse and/or neglect of her children.

Family of origin relationships are quite strained for SAFE women. Family members either share the client's lifestyle or have disengaged out of discomfort with the client's drug use and lifestyle. And yet, family members may be pulled back in during episodes of crisis to take rescuing action on behalf of the client. The social worlds vary for SAFE women. Some are socially isolated, enmeshed in a solitary world of drug use surrounded only by a few primary relationships with active users or persons who support, via enabling, their continued drug use. Other SAFE women are deeply enmeshed in a culture of addiction, an exciting world of people, places and activities all of which reinforce sustained drug use. The drugs and the roles and relationships in the culture of addiction all hold out the promise of pleasure and power but alas, as a metaphor for her life, bring betrayal in the form of pain and loss.

The etiology of the neglectful/abusive behavior exhibited by the SAFE client toward her children springs from multiple sources: the emotional deficits and debilities resulting from her own family of origin experiences, the lack of appropriate parenting skills, environmental chaos that competes with parenting responsibilities, increased loss of control over the drug relationship, and sustained exposure to a predatory drug culture. She constitutes the ultimate paradox of motherhood. Scorned and shamed by those who don't know her ("How could a mother neglect her child because of a drug?"), her desire to remain the mother of her children will remain the primary external force that sustains her through the change process.

In short, the woman who will come in contact with Project SAFE is compulsively involved in dependent relationships with abusable substances and abusing people, lives in environments that are chaotic and traumatizing, and is constitutionally incapable of a self-initiated, spontaneous break in this dependent lifestyle. All of her experiences have confirmed that the world is a physically and psychologically dangerous place. Her contacts with helping professionals during this stage are likely to be marked by passive compliance (role playing) or by open disdain and distrust.

There is, however, as much strength in this profile as pathology. The ultimate pathology is the environmental pathology which demanded that SAFE women sacrifice their esteem and identity as an act of survival. While the consequences of these adaptations may appear as pathological personality traits to those unfamiliar with such traumatizing environments, seen from another perspective, these are stories of survival and incredible resiliency. The strength inherent in sheer survival is the seed from which the recovery process will eventually sprout. That seed must be acknowledged, nurtured and channeled into the change process.

## **Stage 2: Institutional Dependency**

The initiation of sobriety and the period of early recovery for SAFE women is marked by decreasing dependence upon drugs and unhealthy relationships, and an increasing dependence upon Project SAFE staff and the institution within which it is nested. Stage 2 is marked by the following three phases: 1) testing and engagement, 2) stabilization, and 3) reparenting.

Rarely if ever do Project SAFE women present with a high level of motivation for change. The earliest stage of engagement is usually induced by external fiat (court mandated treatment or fear of losing children) or through the persistence of an outreach worker. Whether presenting with

superficial compliance or open hostility, the engagement period is a ballet of approach-avoidance and ambivalence. The tipping of the scales are often shaped by the relative interactions of hope and pain. There is a hope-pain synergism (illustrated below) that dictates the outcome of our efforts at engagement.

### The Hope-Pain Matrix

High Pain HP	Low Hope LH	HP-LH most typical initial pattern encountered with SAFE women. External control and hope-engendering relationships key ingredient to treatment engagement
High Hope HH	Low Pain LP	HH-LP represents honeymoon phase in drug relationship. Drug relationship experienced as solution rather than problem. Poor treatment success; high risk of relapse.
HP-HH produces high internal motivation and rapid engagement in treatment. Good treatment prognosis.	LH-LP represents post-honeymoon phase of drug relationship. Trust building by OR workers can set stage for treatment engagement during crisis.	

Where there is high pain and high hope, a rarity, engagement can be quick and intense. Where there is low pain and low hope, there is minimal chance of treatment initiation. It is in the combinations of high pain and low hope and high hope and low pain, that the intervention technology of outreach can work its magic of persistence and consistent positive regard to alter the equation to get treatment engagement. (See Chapter Five for a discussion of this technology.)

The earliest relationship between SAFE women and the treatment milieu is one of great ambivalence. Clients maintain a foot in both worlds (addiction and treatment) gingerly testing each step forward and backward. In this transition period can be found enormous incongruities and contradictions, e.g., clients who want to keep using drugs AND keep coming to treatment, clients who want staff to go away because staff make them feel good and hopeful. While this ambivalence may have its subtleties, it is most often played out behaviorally in dramatic fashion, e.g., missed days of treatment attendance, splitting in anger and then calling to seek reconciliation, relapse behavior, etc. True emotional engagement is rarely a bolt of lightning event. It is much more likely to be a slow process of engagement with every stage marked by testing behaviors.

The earliest experiences of positive regard and hope experienced by Project SAFE women can trigger strong counter reactions. The woman who too quickly reveals her secret self may react in anger (temper tantrums) or in flight (missed meetings). The hope-instilling positive regard from SAFE staff may escalate a client's self-defeating patterns of living, e.g., setting others up to reject her as a confirmation of her life positions that trust is foolish and nowhere is safe. When staff refuse to be driven back by these exaggerated defense structures, the client is forced to experience herself differently and to rethink her beliefs about herself and the world. This testing, experiencing acceptance and rethinking process may go on in its most intense forms

for weeks before a woman fully commits herself to the SAFE program. For women who get through this initial stage, testing may resurface later during critical developmental milestones in the recovery process. For women who cannot resolve this trust/safety issue, their drug using lifestyle will continue unabated.

In the stability phase, outreach and case management services provided through project SAFE have reduced the environmental chaos (housing, transportation, legal threats, etc.) to manageable levels and overall treatment efforts have created an initial (but still fragile) emotional bond between the client and the treatment team. As external threats to safety and survival subside, the Project SAFE client begins to master the personal and social etiquette of SAFE participation, e.g., regular attendance, group participation, etc. As soon as sobriety and environmental stability begins, emotional thawing and volatility escalates.

This can be a stage of raw catharsis. Pent-up experiences unleash powerful emotions when first aired to the outside world through storytelling. With the experience of safety, clients can begin peeling away and revealing layers of the secret self only to discover dimensions that were unknown even to themselves. Healing of this pain will occur in levels through all of the stages described in this model. At Stage 2, the most crucial dimension is the experience of acceptance by others following self-disclosure. There is, at this stage, a sense that shared pain is diminished pain, and that secrets exposed to the light of disclosure lose their power to haunt and control.

There are several dimensions of reparenting within Project SAFE spread over the developmental stages of recovery outlined here. At this early stage, Project SAFE takes over a parental role with project clients, tending to issues of survival and safety. It is a nurturing, “doing for” process. At an emotional level it involves experiencing unconditional “thereness” -- the consistent physical and emotional presence of the program in the life of the client. It involves the experience of consistency, a non-voyeuristic and non-judgmental openness to their life stories, and the ability to tolerate testing, but still set limits. It is the experience that one can mess up, but not jeopardize one’s status as a family (SAFE) member. As clients become more receptive to this emotional nurturing, they may regress and become quite dependent upon the program. This escalating dependence should be seen not in terms of pathology, but in terms of a developmental process of healing. It is through this increased dependence, and the needs that are being met through it, that the client begins to fully disengage from active involvement in the culture of addiction. The program must now meet all those needs which the client formally met within the society of addicts. The program must be available to fully fill this vacuum at this stage if contact with the culture of addiction is to be broken. Does that mean that a stage of “doing for” the client, a stage of consciously cultivating client dependence upon the treatment institution, is clinically warranted? YES!

Key developmental tasks that must be mastered by the client during Stage 2 include:

- Resolving environmental obstacles to recovery.
- Working through the ability to maintain daily sobriety.
- Relationship building with staff that transcends stereotyped role behaviors of “client” and “professional helper” (movement beyond compliance).
- Learning etiquette of program participation.
- Breaking contact and asserting isolation from culture of addiction.
- Exploring limits of safety in the treatment environment via storytelling and boundary testing.

- Accepting nurturing from project staff.
- Verbalizing, rather than acting out, compulsions of fight or flight.

During Stage 2, clients still have little sense of personal identity. Where identity in Stage 1 was formed through identification with a drug, a drug culture, and a small number of highly abusive relationships; identity in Stage 2 comes through drug abstinence, identification with a treatment culture, and a small number of highly nurturing relationships. Denial dissipates during Stage 2 and personalized talk about alcoholism/addiction reflects the growing recognition of “addict” as an element of identity. Clients still need external sources of control over their behavior, although these sources begin shifting from negative (judicial coercion) to positive (regard for relationships with staff).

Clients who get stuck in Stage 2 (and programs which conceive of Stage 2 as the terminal stage of treatment) contribute to the growing population of chronically relapsing clients who, fail to function either in the culture of addiction or in the society at large, become institutionalized clients in the substance abuse treatment system.

Stage 2 begins the reconstruction of the relationships between the SAFE mother and her children. With the resolution of environmental chaos, the initiation of sobriety, and early engagement in treatment, the most dysfunctional aspects (neglect and abuse) of the parent-child relationship have been addressed, but it may be some time before quality parenting will appear. Early recovery parenting efforts often reflect a lack of basic parenting skills and efforts to compensate for guilt related to past drug-related deficiencies in parental effectiveness, e.g., overprotection or overindulgence. As the mother herself experiences reparenting in relationships with staff, she becomes more empowered to mirror these experiences with her children, e.g., feedback, nurturing, boundary setting, problem solving, etc.

### **Stage 3: Sisterhood**

In Stage 3, relationships of mutual respect and trust established between the client and the Project SAFE staff begin to be extended to encompass other women clients in the SAFE project (one’s treatment peers). The earliest efforts in these peer to peer relationships are marked by diminished capacity for empathy, the inability to listen to another with the roar of one’s own ego in check, the lack of social etiquette, and the need to clearly proscribe the limits of trust. Clients speak at the same time, fail to respond emphatically to painful self-disclosure, make commitments to each other that are broken, react to feedback with verbal attack or threats of violence or flight, etc. It is the treatment milieu that must provide the skill development and the relationship building processes to weld these disparate individuals into a mutually supportive group.

Over time, clients begin to extend their trust and dependence upon staff to a growing reliance on the help and support of their treatment peers. Within the structure of the treatment milieu, they move from the position of “none can be trusted” to a realistic checking of who can be trusted and the limits of that trust. The early friendships between treatment peers constitutes the embryo of what will later be a more fully developed culture of recovery. As skills increase, the client learns to not only speak, but to listen; to not only receive feedback, but to offer feedback; to not only receive support, but to give support. It is crucial that treatment staff provide permission and encouragement for decreased dependence upon staff and increased dependence on other health-enhancing relationships within and beyond the treatment milieu.

The peer milieu is an important vehicle through which Project SAFE women wrestle with

some of their most troublesome treatment issues. This is the milieu within which sexual abuse and other family of origin pain is explored. It is here that they can grieve their many losses. This is the arena within which abusive adult relationships are mutually confronted. This is the arena in which clients come together collectively to fight back against shame and stigma to restore their honor and self-respect both as women and as mothers.

During this stage, there is an intense exploration of victimization issues. Stories of victimization are shared. Catharsis of pain and anger is achieved. A “sisterhood of experience” is achieved. Early identity reconstruction focuses on victimization issues. Individual and collective identity focuses heavily on what has been done to them. Projection is the dominant defense mechanism. The client sees herself in trouble due to persons, institutions and circumstances over which she has no control. It will be some time before this focus can shift to her responsibilities, her choices, her role in her current life position.

Key developmental tasks that must be mastered during Stage 3 include:

- Extension of self-disclosure to treatment staff to treatment peers.
- Early relationships with recovering role models encountered within the treatment site.
- Exploration of victimization issues.
- Rapid expansion of social skills (parallels period of early adolescent development).
- Treatment agency focused lifestyle develops as alternative to culture of addiction.
- Shift in relationships from drug-oriented to recovery-oriented.

Stage 3 is the first time SAFE clients begin to experience themselves as part of a broader community of recovering women. Identity and esteem are increasingly based on identification with this community. The shift in identity from “addict” to “recovering addict” marks a beginning stage in the reclamation of the self. These shifts in identity are not without their risks as we shall see in the next Stage.

Major risks of relapse during Stage 3 come from panic, secondary to emotional self-disclosure, relationship problems between treatment peers, and failure to sever or reframe past drug-oriented intimate and social relationships.

#### **Stage 4: Selfhood and Self-help**

Where Stage 3 focused on shared experiences, SAFE clients in Stage 4 begin some differentiation from the treatment group. There is more focus on personal, as opposed to collective experience. The “victim” identity diminishes during this stage and there is a greater focus on self-responsibility. This stage involves an exploration and expiation of emotion surrounding one’s own “sins” of commission or omission. Treatment time shifts from what “they” did to what “I” did. There is a confessional quality to early work in this stage with, self-forgiveness being a critical milestone. There is, for the first time, a shift in focus from personal problems to personal aspirations. This stage marks the beginning reconstruction of self that will continue throughout the lifelong recovery process.

In Stage 4, Project SAFE women begin to experiment with the development of health-enhancing relationships outside the treatment milieu. Having developed some sense of safety and

identity within the treatment milieu, they seek to extend this to the outside world by finding networks of long-term support. The two most frequent structures utilized by Project SAFE clients for such support in Stage 4 are self-help groups and the church. This is a critical stage through which the emotional support the SAFE client has received from treatment staff and treatment peers is extended for the first time to a broader community beyond the treatment site. There is also a focus on rebuilding strained or ruptured family relationships during this period. With sustained sobriety and program involvement and obvious changes in her lifestyle, estranged family members once again open themselves to reinvolvement with SAFE clients.

Self continues to be defined in Stage 4 through external relationships. A period, perhaps even a sustained period, of extreme dependence upon this support structure, while criticized by persons not knowledgeable about the developmental stages of recovery, can be the critical stage in the movement towards long-term recovery. During this period, the client's whole social world may be shaped within the self-help or religious world. This period constitutes a period of decompression from the toxicity of the culture of addiction and a period of incubation within which the self and self-world relationship are reconstructed.

If the shift in dependence from the treatment milieu to outside supports is made too quickly, the client will experience this encouragement for outside relationships as abandonment by the treatment staff. Traditional short-term treatment models that encourage this shift at a very early stage in recovery may inadvertently recapitulate the client's fear and experience of loss and abandonment. In Project SAFE, we found that these relationships needed to supplement, rather than replace, those primary relationships of support within the treatment milieu.

There is a reassessment and decision point during Stages 3 and 4 as whether to move forward in the recovery process or to retreat back into the world of addiction. During these stages, the full implications of the recovery lifestyle become clear. There is fear that long term recovery is still not a possibility. There is fear of the future unknown and their ability to handle it. As bad as the past is, it continues to exert its seductive call as a world they know better than any other. If treatment contact and support is prematurely ended during this stage, relapse is likely.

### **Stage 5: Community Building**

In Stage 5, SAFE women extend their system of supports into the broader community. It is at this stage that clients must figure out how to maintain sobriety while fully living in the world. It is a stage of lifestyle reconstruction. Friendships that are based neither on active addiction nor shared recovery are explored and developed. The earliest activities within this stage may begin very early or very late in the recovery process. For SAFE women, the earliest activities are often initiated via outreach workers. Tours of community institutions, getting a library card, going on picnics, bargain hunting at garage sales and flea markets, and experimenting with drug-free leisure may all be aspects of community building initiated through the treatment experience. A major aspect of Stage 5 is the establishment of drug free havens and drug free relationships that can nurture long-term recovery. Another aspect of this stage is the repositioning of the family in the community, re-establishing old healthy linkages to community institutions and building new linkages.

It is important that treatment staff possess a sensitivity to non-traditional pathways to recovery. Many recovering women may set the roots of their recovery in institutions other than traditional self-help groups. The church served as a primary support institution to many SAFE

women, either as an adjunct or an alternative to traditional addiction self-help groups.

The parenting of SAFE mothers changes in a number of ways during these later stages of recovery. Earlier stages set the groundwork through the acquisition of basic parenting skills and working through stages of overindulgence and overprotection. The emotional needs of the mother are so intense early in the recovery process, that it is very difficult for her to maintain a sustained focus on the needs of her children. In Stage 5, however, the intensity of these internal needs have been addressed to allow for a much richer quality in the relationship between the client and her children. Where she achieved consistent physical presence in earlier stages of recovery, she now creates a consistent emotional presence in the life of her children.

There is also a shift in Stage 5 in the relative health of the client's intimate relationships. Abusive relationships which may continue into the early stages of recovery have now been changed or severed. Some, at this stage, will have gone through experimentation with a variety of relationships, some will have found a primary long-term relationship, while others may find themselves content for the time being to seek their destiny without the security or burden of a primary relationship.

### **Stage 6: Interdependence**

Stage 6 in the developmental progression of recovery for SAFE women, constituted not by a fixed point of achievement, but entry into a lifelong process of doubt, struggle, and growth. The shift from the earliest stages is one from self-negating dependence to self-affirming interdependence. This stage is marked by the emergence and continued evolution of an identity that transcends both the addictive history and the history of involvement with helping institutions. In a literal sense, this self-emergence is really not a "recovery" process, since recovery implies a recapturing or retrieval of something one once had. This is not retrieval of an old self; it is the creation of a new self. It is more a process of "becoming" than a process of "recovering."

Due to the lack of long term follow-up studies of Project SAFE, we don't know a lot about this stage of recovery for SAFE women. We do have inklings of some of the elements within this stage as more and more women stay in touch with the staff over a period of years. It seems to be marked by:

- Movement toward one's personal aspirations, often reflected in achievement of some personal milestone, e.g., completing high school, getting into college, and gaining employment.
- Working through the tendency to substitute drugs with other excessive behaviors, e.g., workaholism, food, and sex.
- A maturing out of the narcissistic preoccupation with self that characterized active addiction and the early stage of recovery.
- The creation of a social network in which relationships are characterized by mutual respect and support.
- The organization of one's life around a set of clearly defined values and beliefs.
- The emergence of acts of service to other people (including, for some, coming back years later to work as outreach workers in Project SAFE).

There is tremendous diversity in how women within Project SAFE have experienced, or failed to experience, the recovery process. For some, sobriety and the enhancement of parental

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functioning were introduced into an otherwise unchanged life. For others, Project SAFE would represent the beginning of a life-transforming recovery process. It is our hope that this paper has captured some of the shared experiences that transcend this diversity.

# APPENDIX C

## **Defining Gender Specific Addiction Treatment/Recovery Historical Milestones**

- Laws in ancient Rome permitted husbands to kill their wives for being drunk.
- 1835 Dr. Robert MacNish reported that the practice of encouraging women to drink ale as an aid to nursing was leading to a growing problem of female inebriety.
- 1841 First Martha Washington Society (1841) founded in New York to provide support for inebriates, to offer special help to the female inebriate, and to offer help to the wives and children of inebriates. Other groups will follow: Daughters of Rechab, Daughters of Temperance, Sisters of Samaria, Daughters of Samaria.
- 1841 Industrial homes” for inebriate women opened by temperance groups.
- 1842 Issac Shephard pens *Confessions of a Female Inebriate*.
- 1860s 400 of the first 4,000 applications for admission to the New York State Inebriate Asylum were from women.
- 1860s Dr. Edward Turner incorporates the Women’s National Hospital for Inebriates and Opium Eaters in Connecticut but efforts to raise the resources to build and open this treatment facility fail due to Turner’s past failure in New York.
- 1867 Martha Washington Home in Chicago opened: first specialty facility for addicted women.
- 1869 Female Department of the Chicago Washingtonian Home admits 50 women in its first 18 months of operation. More than 1,3000 women will be treated by the year 1900. Treatment for women (4 weeks) was twice as long as that for men. Women were reported to have better outcomes than men; this was attributed to the belief that they were less inclined to the habit.
- 1870s Ladies Dashaway Association in San Francisco offers aid and support to female inebriates.
- 1874 A report of the Albany Penitentiary notes that nearly all of the 6,000 women incarcerated there are inebriates.
- 1876 Temple Home, an inebriate home for women, opens in Binghamton, NY, but operates only a few years.
- 1877 Thomas Doner reflects on shame attached to female drunkenness.
- Men can reform; society welcomes them back to the path of virtue...their promises to reform are hailed with great delight. But, alas! For poor women who have been tempted to sin by rum. For them there are no calls to come home; no sheltering arm; no acceptance of confessions and promises to amend ... How seldom we attempt to reach and rescue her! For here there is no refuge.*
- 1879 The New England Home for Intemperate Women opened.

- 1880s Dr. Lucy Hall, Physician in Charge of the Reformatory Prison in Sherburne, MA reports on 204 inebriate women. 109 had 2 or more prior commitments for drunkenness-related offenses. As a group they began drinking before age 21, usually drank with other young women, and progressed from alcohol-laced tonics to beer and spirits. More than 1/3 had prior experience of being battered by their husbands.
- 1880s/1890s To escape the growing moral stigma associated with intemperance, addicted women are allowed to use false names while being treated in inebriate homes and asylums.
- 1884-1912 Mark Lender's review of treatment admissions for women to inebriate homes/asylums reveals a male to female ratio ranging from 3:1 to 9:1.
- Early 1890s St. Savior's Sanitarium in New York opened for the care of inebriate women.
- 1890s Addicted women coming to Dwight, IL are placed in the "Ladies Home"—several blocks away from where male patients are boarded.
- 1898 Dr. Agnes Sparks suggested that women had less genetic risk of inebriety than men but greater risk related to: 1) neurasthenic weakening produced from poor nutrition and domestic duties, and 2) painful disorders of their sex. She suggests that inebriate women have a better prognosis for recovery following treatment than do male inebriates.
- 1900 An article in the Catholic World notes the growing problem of intoxicated women showing up at day nurseries to pick up their children.
- 1901 Dr. Heywood Smith attributes the problem of female inebriety to the stress brought on by their growing independence, the practice of champagne drinking, and the growing presence of alcohol in grocery stores.
- 1900-1960s A eugenics movement successfully lobbies for passage of mandatory sterilization laws that include alcoholics and addicts. The practice of "de-institutionalization contingent upon sterilization" was a common practice applied to alcoholic women committed to state psychiatric hospitals.
- 1928-1970 Shuckit's review of research on alcoholic women noted only 28 such studies between 1929 and 1970.
- Early 1940s Women's groups in AA begin.
- 1944 Marty Mann Launches the National Center Education on Alcoholism.
- 1972 Reports on what will come to be called fetal alcohol syndrome stir interest in new approaches to engage and treat alcoholic women.
- 1984 New federal block grant regulations require states to set aside 5% funds for specialized services for women.
- 1987 Early anecdotal reports on the effects of prenatal cocaine exposure launch a media frenzy about "Crack babies" that pushes policies for removal of children from

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mothers that have delivered drug-exposed infants and that criminalizes drug use during pregnancy.

- 1988-1989 “Women’s set aside funds” are doubled as a result of reports regarding cocaine exposed infants.
- 1993 The NIH Revitalization Act requires that women and minority groups be included in all NIH-sponsored clinical research.
- 1995 States increase funding for demonstration projects that focus on developing innovative models of treating addicted, multiple problem clients.
- 1990s NIDA-funded research on prenatal cocaine exposure concludes that such exposure results in subtle effects to some infants that can be either overcome by the brain itself or by environmental supports. Such reports go virtually unnoticed.
- 1980s-1990s More research on addicted women is conducted in this 20 years than in the previous 200. These studies confirm significant gender differences in biological effects of alcohol, the etiology of addiction, patterns of addiction, obstacles and response to treatment, and long term recovery pathways and styles.