DRUG POLICY & HISTORY

Drug Policy, Drug History and Social Context

William L. White — Selected Papers, Volume VIII

10 Papers

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Themes in Chemical Prohibition

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The study of the historical themes in chemical prohibition movements can provide a helpful tool in understanding those institutionalized beliefs and myths which pose powerful barriers to any alteration in social policy on "drug abuse." This paper identifies the nature of those themes and presents the author's perceptions of how these inherited belief systems have severely limited our options for more enlightened and effective strategies for the social control of chemical intoxication.

Chemical intoxicants have been available to humans in almost all cultures since the beginning of time. Each culture through succeeding generations has assumed the task of defining and redefining which chemicals will be blessed, celebrated or tolerated and which chemicals will be forbidden, legally prohibited, and condemned. In like manner each generations has confronted what the policy would be toward those persons who disobeyed the rules about the use of chemical intoxicants. The conversion of these policy definitions into law has often followed prohibitionist mass movements which sought through a variety of propaganda techniques to instill in the culture at large a certain set of beliefs and fears about the drugs in questions. When these movements have been effective at generating statutory prohibition of specific drugs, this set of beliefs and feelings toward certain chemicals and persons who use them evolves over time to the point where they are seen as flowing from unchallengeable sources. At this stage, alternatives to the policies that reflect these prohibitionist themes are viewed as unthinkable.

This paper is based on the following premises:

1. Current strategies toward the use and abuse of mood-altering drugs continue to be based on a set of beliefs generated from the prohibitionist movements of the late 19th and early 20th centuries.

2. The cementing of these prohibitionist beliefs into the very social fabric of American culture is one of the primary barriers to changing an outmoded and nonfunctional social policy. The integrations of these

beliefs into our culture has been so complete that to question them is immediately experienced by the culture at large as an attack on the institutions which have proliferated these beliefs, e.g., our national leaders, the law, our educational and religious institutions, and the family.

3. The development of national policies toward mood altering drugs has not and cannot be intelligently addressed until we expose and modify the irrational fears and beliefs upon which current policies are based.

This paper will identify the nature of these inherited beliefs and describe the manner in which they have prevented development of a more enlighten and effective strategy for the social control of mood altering drug use in our society.

THE PROHIBITIONIST THEMES

A review of chemical prohibitionist literature reveals eight themes which appear to emerge from the tactics of most such movements. The tactics utilized to produce these themes are as follows:

1. The drug is associated with a hated subgroup of the society or a foreign enemy.

2. The drug is identified as solely responsible for many problems in the culture, i.e., crime, violence, insanity.

3. The survival of the culture is pictured as being dependent on the prohibition of the drug.

4. The concept of "controlled" usage is destroyed and replaced by a "domino theory" of chemical progression.

5. The drug is associated with corruption of young children, particularly their sexual corruption.

6. Both the user and supplier of the drug are defined as fiends, always in search of new victims; usage of the drug is considered "contagious."

7. Policy options are presented as total prohibition or total access.

8. Anyone questioning any of the above assumptions is bitterly attacked and characterized as part of the problem that needs to be eliminated.

Each of the above will be reviewed looking at their historical development and their present status.

The Drug is Associated with a Hated Subgroup of the Society or a Foreign Enemy

The association of particular drugs with hated minority groups and foreign enemies has a long and colorful history in the United States. The association of opium with the Chinese, of cocaine with Blacks, or alcohol with urban Catholic immigrants, of heroin with urban immigrants, of Latinos with marijuana, the claim that a myriad of foreign enemies were using these drugs against the U.S., and the image of drug crazed bohemians such as Ludlow, Baudelaire, and DeQuincy all were integral to the propaganda that generated the prohibitionist policies on each of these drugs.

San Francisco passed the first narcotics law in the United States in 1875 for the purpose of suppressing opium smoking. There is little doubt that this law was aimed specifically at the Chinese and reflected more an attempt to control the Chinese as an economic group that it did a concern about the drug opium. The "Chinese Question" dominated California politics in the 1870's. The period is marked by intense racial and class conflict. Racial riots occurred in numerous West Coast cities that resulted in the killing and lynching of Chinese and the burning of Chinese quarters. The California Workingman's Party was organized under the cry "The Chinese must go!" California representatives with the support of their southern counterparts pushed through Congress the Chinese

Exclusion Act of 1882 which suspended immigration of Chinese workingmen into the U.S. for ten years. It is doubtful given this background that the 1875 ordinance in San Francisco was aimed at protecting the health and welfare of the Chinese people.[1, 2, 3 and 4]

Although the practice of smoking opium in the early 1870's was unquestionably limited to the Chinese, the continued association between opium and the Chinese into the 1900's as part of the drive for national legislation to prohibit opium is unfounded. During this period opium had become a primary ingredient in over the counter medications sold as a cure-all for an unending list of ailments. Terry and Pellens in their classic work The Opium Problem summarize all available surveys on opium use and conclude that most of users were white, female, middle-aged, and to be found among the educated and most honored members of society.[5] Despite this evidence, the association between opium and the Chinese continued. Dr. Hamilton Wright, M.D., a State Department Official, referred to many as the father of American Narcotic laws was before Congress in 1910 propounding the recurring theme of miscegenation with the following comments: "One of the most unfortunate phases of smoking opium in this country is the large number of women who have become involved and were living as common law wives or cohabitating with Chinese in the Chinatowns of our various cities."[6] As with prohibitions which would follow, people's attitudes toward a specific drug (opium) became inseparable from their feeling about that group of people (Chinese) with which the drug's use was associated.

The association between cocaine and Blacks during the late 1800's and early 1900's was both direct and vicious. Hamilton Wright was again on the scene in 1910 giving Congress the following warning about cocaine: "It was been authoritatively stated that cocaine is often the direct incentive to the crime of rape by the Negroes of the South and other sections of the country."[7] The following additional example comes from an article by Edward Huntington Williams, M.D., in The Medical Record in 1914:

> *Once the Negro has reached the stage of being a 'dope taker' (dope here referring to cocaine)....he is a constant menace to his community until he is eliminated....Sexual desires are increased and perverted, peaceful Negroes become quarrelsome, and timid Negroes develop a degree of 'Dutch courage' that is sometimes almost incredible....In the language of the police officer, 'The cocaine nigger is sure hard to kill' - a fact that has been demonstrated so often that many of these officers in the South have increased the caliber of their guns for the express purpose of 'stopping' the cocaine fiend when he runs amuck*.[8]

A review of more popular reading of the day would have revealed the following statement in a 1914 Literary Digest article: "Under its (cocaine) influence are most of the daring crimes committed...Most of the attacks upon white women of the South are the direct result of a cocaine crazed Negro brain."[9] Or consider the following attributes of cocaine as reported again by Edward Huntington Williams, M.D. in an article in the New York Times:

> *The list of dangerous effects produced by cocaine.... is certainly long enough. But there is another, and a most important one, this is a temporary steadying of the nervous and muscular system, so as to increase, rather that interfere with good marksmanship....the record of the 'cocaine nigger' near Asheville, who dropped five men dead in their tracks, using only one cartridge for each, offers evidence that is sufficiently convincing*.[10]

As if these racial associations were not enough, a New York Times article on the cocaine "menace" during this period tapped

the anti-Semitic constituency with the following: "...there is little doubt that every Jew Peddler in the South carries the stuff." The constant racial associations with cocaine may account for the fact that, between 1887 and 1914, laws were passed in 46 States regulating cocaine whereas only 29 States had enacted such laws to regulate the opiates.[12] Perhaps an added irony is a 1908 report by the Federal Government indicating more than 40 brands of soft drinks which contained cocaine.[13]

Moving along to the next chemical which had long been singled out as a prohibitionist target, we see Congressman Hobson in 1914 in defense of his resolution for an alcohol prohibition amendment using a tactic that had been working well to influence the prohibition of cocaine and opium:

> *Liquor will actually make a brute out of a Negro, causing him to commit unnatural crimes. The effect is the same on the white man, though the white man being further evolved it takes a longer time to reduce him to the same level*.[14]

Liquor, as the story went, encouraged the southern Negro to "loose his libido on white women, incited....by the nudes on the labels of whiskey bottles." At home and abroad, prohibitionist missionaries began spreading the word that the poor and "colored people" of the earth were dangerous when drunk. As we approached World War I, however, a much bigger target was found. Pabst and Busch were German. Liquor stopped soldiers from shooting straight. Grain for alcohol took food away from starving allies. Liquor was unpatriotic. By the time prohibition of alcohol was implemented in 1919, alcohol was strongly associated with German war effort, Catholicism, and the growing urban environment with its high percentage of foreign immigrants.[15] The entire prohibition drama was to a great extent a symbolic issue of power - a question of whether the United States would be ruled from the traditions of rural Protestant America or by growing industrial cities with their heavy immigrant Catholic influences.

The next major prohibition effect occurred in the 1930's as momentum was building to outlaw the use of marijuana. Harry Anslinger, in testifying in support of the Marijuana Tax Act of 1937, presented a letter from a Colorado newspaper editor, an excerpt of which follows:

> *I wish I could show you what a small marijuana cigarette can do to one of our degenerate Spanish speaking residents. That's why our problem is so great; the greatest percentage of our population is composed of Spanish-speaking persons, most of whom are low mentality because of social and racial conditions*.[16]

The association between marijuana and Latinos continued throughout the 1930's and it is doubtful that any of the legislators in 1937 could have even conceived of the possibility of large numbers of their own grandchildren and great grandchildren using marijuana and going to jail under a legal precedent they set.

An added twist to this overall theme was the proposition by Harry Anslinger, Commissioner of the Bureau of Narcotics, that Communist China was growing and producing large quantities of opium and heroin for export to the free world, the United States in particular. This distribution of narcotics within the United States was part of the "Yellow Peril" which threatened to weaken America for the kill.[17] Although Anslinger is most famous for this conspiracy theory of drug abuse, it was by no means original with him. A number of articles in the New York Times during 1918 charged German agents with smuggling drugs to American Army bases and public schools. The following excerpt from the December 18 issue is typical of the tone:

> *Until well-known German brands of toothpaste and patent*

> *medicines....naturally for export only... habit forming drugs were to be introduced; at first a little, then more, as the habit grew on the non-German victim and his system craved ever increasing quantities.... in a few years Germany would have fallen upon a world which cried for its German toothpaste and soothing syrup...a world of "cokeys" and "hop fiends" which would have been absolutely helpless when a German embargo shut off the supply of its pet poison*.[18]

The reporting of the drug abuse "epidemic" of the 1960's and early 1970's and the demands for increasing prohibitions was only qualitatively different from these earlier campaigns with the association between "drugs" and radical left politics, social violence, defiance of respected values, etc. The theme was the same only the hated subgroup and the nature of the foreign enemy had changed.

The above material represents only a small part of the information available to document the prohibitionist's association of a drug with either a hated minority group or a foreign enemy. Similar data can be found when one looks at the short lived movements to prohibit tobacco and coffee.

Richard Hostadter's comment that "Reformers who begin with the determination to stamp out sin usually end by stamping out sinners"[19] seems applicable here. It is open to historical interpretation which the prohibitionists were more interested in prohibiting, cocaine, opium and alcohol or the existence of black, Chinese, and Latinos in the United States. Although a racial theory of the development of drug control policies would be much too simplistic, it is unquestionable that the racial and "foreign conspiracy" associations with different drugs were instrumental in crating the emotional environment from which early prohibitionist laws sprang. There is also little question that modern versions of this theme continue to touch of primitive and powerful fears about the welfare of our country, our institutions, and most importantly the welfare of our children.

<u>The Drug is Identified as Solely Responsible for Many Problems in the Culture, i.e. Crime, Violence, Insanity.</u>

The attributing of crimes of violence, sexual assault, insanity, moral decay, etc. have been an integral part of efforts to prohibit the currently illicit drugs. A key element in this theme is the arbitrary designation of "good" and "evil" drugs with evil drugs possessing powers that can overwhelm all efforts at human control. "The Devil made him do it" is changed to "the drug made him do it." This aspect of prohibitionist philosophy is so often reported, there is no need to belabor the point. A few illustrative examples will be outlined.

A prohibitionist movement, which was short lived but quite capable of attributing the evils of the world and the devastation of human beings to its particular despised chemical, gave wide circulation to a statement by Sir Clifford Allbut, M.D. and Walter Dixon, M.D. which appeared in <u>A System of Medicine</u> in 1909. At the time, Sir Clifford was a professor of internal medicine at the University of Cambridge in England and Dr. Dixon was a professor of pharmacology at Kings College in London. An excerpt follows:

> *The sufferer is tremulous, and loses his self-command; he is subject to fits of agitation and depressions, he loses his color and has a haggard appearance. the appetite falls off, and symptoms of gastric catarrh may be manifested. The heart also suffers, it palpitates, or it intermits. As with other such agents, a renewed dose of the poison gives temporary relief, but at the cost of future misery*.[20]

The substance referred to is coffee, and the statement was circulated for a short time in an attempt to garner support for the prohibition of coffee.

The anti-tobacco forces were much better organized (with cigarettes still illegal in 14 states in 1921)[21], and their pronouncements received wide distribution. The following statements are representative of those used by the anti-tobacco forces from 1920 to 1935, Louis Lewin, an eminent authority on pharmacology, wrote the following in 1924 which received wide distribution:

> *The juvenile female flower of the nation, the 'Emancipata femans vulgaris' (Lewin's term for the feminists of his day,) who should bear fruit in time to come.....frequently fails to do so because the foolish consumption of cigarettes has impregnated the sexual organs with smoke and nicotine and keeps them in a state of irritation and inflammation*.[22]

A 1930 issue of the National Advocate reported a doctor's opinion that "Sixty percent of all babies born of mothers who are habitual smokers die before they are two years old."[23] An anti-tobacco publication of 1931 included the following:

> *Fifty percent of our insanity is inherited from parents who were users of tobacco; sometimes the victim is a smoker himself, which hastens it on. Thirty percent of insanity cases are caused directly from cigarette smoking and the use of tobacco....*[24]

Several anti-tobacco publications of the 1920's quoted New York City Magistrate to illustrate the crime producing properties of tobacco:

> *Ninety-nine out of a hundred boys between the ages of 10 and 17 who come before me charged with a crime have their fingers disfigured by yellow cigarette stains*. [25,26]

Tobacco was also reported to be the hidden cause of increased suicides in the early 1900's:

> *The publisher of this book...has had two men in his employ who used cigarettes...They both committed suicide. They became so despondent and so sick of a life as they were living that they murdered themselves. This is the end to which many cigarette smokers come*.[27]

f we look at the few years preceding passage of the Marijuana Tax Act in 1937, we see equally vociferous statements on the evils and destructiveness of marijuana. An advertisement distributed by the Federal Bureau of Narcotics in 1935 read as follows:

> *Beware! Young and Old---People in All Walks of Life! This (picture of a marijuana cigarette) may be handed to you by the friendly stranger. It contains the Killer Drug 'Marijuana' - a powerful narcotic in which lurks Murder! Insanity! Death!* [28]

In 1936 the International Education Association in conjunction with the Federal Narcotics Bureau published Marijuana or Indian Hemp and Its Preparations which included statements such as:

> *Prolonged use of marijuana frequently develops a delirious rage which....sometimes leads to high crimes such as assault and murder. Hence marijuana has been called the 'killer drug.' The habitual use of this narcotic poison always causes a very marked deterioration and sometimes produces insanity. Hence marijuana is frequently called 'loco weed.'...Marijuana often gives man the lust to kill unreasonably without motive. Many cases of assault, rape, robbery, and murder are traced to the use of marijuana.*[29]

Such reports were not limited to the Federal Bureau of Narcotics. An article in the 1936 March issue of Scientific American included the following:

> *Marijuana produces a wide variety of symptoms in the user, including hilarity, swooning, sexual excitement. Combined with intoxicants, it often makes the smoker vicious, with a desire to fight and kill.* [30]

Up until the end of prohibition of alcohol in 1933, there was a great deal of overlap between those participating in various prohibitionist movements. All of these persons and groups shared an anti-hedonistic ethic which provided a united front politically in their efforts to legally prohibit all pleasure-producing chemicals as well as other pleasurable nonchemical pastimes of humans, i.e., dancing, jazz music, gambling, etc. The years following the end of alcohol prohibition saw the beginning distinctions between good drugs and evil drugs. Those drugs within the experience of the majority of Americans were considered good; those drugs which tended to be used by minority and fringe groups tended to be defined as evil. Thus alcohol, nicotine, and caffeine (coffee) began to become increasingly integrated into the very fabric of American life, whereas cocaine, opium, heroin, and subsequently marijuana and the hallucinogens continued to be defined as evil—physically, emotionally, and morally devastating to the individual and unquestionably destructive to the culture. This definition of certain chemicals as innately good or evil was to germinate from 1933 into the 1960's where we would witness a giant eruption of this issue as adult America was forced to attempt to articulate to their own children the culturally inherited distinction between good drugs (alcohol) and evil drugs (marijuana, etc.).

Survival of the Culture is Pictured as Dependent on Prohibition or Continued Prohibition of the Drug

Implicit in the attribution of society's problems to the use of particular chemicals is the assumption and implication that these problems will disappear as prohibition becomes effective. The elimination of the drug and its use is thus characterized as crucial for the survival of the culture. Such claims have been characteristic of nearly all prohibitionist movements. For example, the following editorial warning appeared in the New York Times on June 28, 1884:

> *The decadence of Spain began when the Spaniards adopted cigarettes, and if this pernicious practice obtains among adult Americans the Ruin of the Republic is at hand*.[31]

Purley Baker writing in the Anti-Saloon League Yearbook of 1914 implores: "If our Republic is to be saved, the liquor traffic must be destroyed,"[32] and Henry Ford speaking in support of alcohol prohibition stated the following in 1928:

> *If the law were changed, we'd have to shut down our plants. Everything in the United States is keyed up to a new pace which started with Prohibition. The speed at which we run our motor cars, operate our intricate machinery, and generally live, would be impossible with liquor. No, there is no chance even for modification*.[33]

Such pronouncements on the presently illicit drugs have been echoed through the past decades perhaps culminating in the announcement by the President Richard M. Nixon in June, 1971 that "The problem has assumed the dimensions of a national emergency...American's Public Enemy No. 1 is drug abuse."[34]

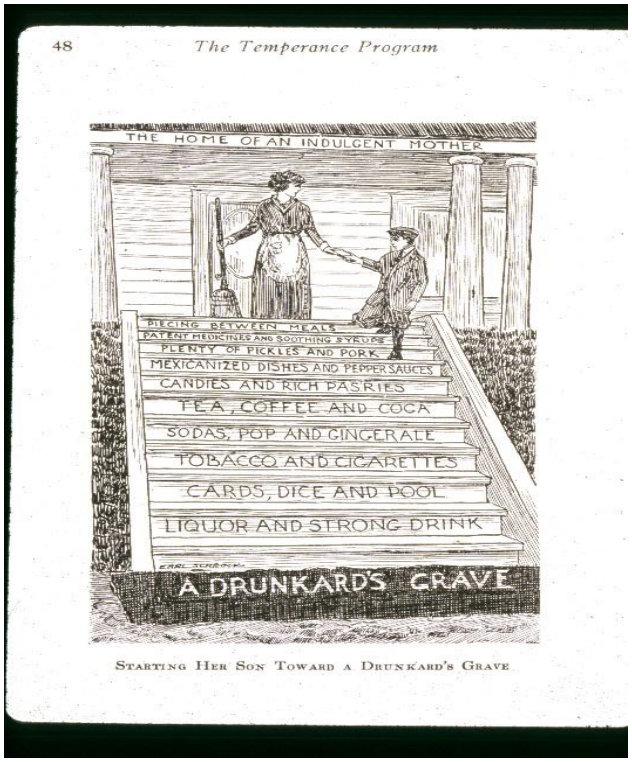
Concept of "Controlled" Usage is Destroyed and Replaced by a "Domino Theory" of Chemical Progression

The history of prohibitionist pronouncements is replete with examples which propose a 'domino theory" of chemical usage. Such a theory holds that the use of a particular drug (usually the one presently targeted for prohibition) inevitably and with rare exception leads to the use of other

drugs (usually drugs already prohibited or drugs already defined as evil). For example, the publication in 1798 of Essays, Literary, Moral and Philosophical by Benjamin Rush includes the following comments from an anti-tobacco essay: "A desire of course is excited for strong drink, (by smoking tobacco) and these (cigarettes) when taken between meals soon lead to intemperance and drunkenness."[35] The following is from a 1912 article in Century magazine:

> *The relation of tobacco, especially in the form of cigarettes, and alcohol and opium is a close one...Morphine is the legitimate consequence of alcohol, and alcohol is the legitimate consequence of tobacco. Cigarettes, drink, opium is the logical and regular series*.[36]

One of the most dramatic and all-inclusive examples of this "domino theory" can be seen in the following illustration from The Temperance Program (1915) of Evangelist Thos. F. Hubbard.[37]



The contention that alcohol abuse was the basis for morphinism was not uncommon in the late 1800's, and more recently the mystical connection between marijuana and heroin has been central to the rationale for continued prohibition of marijuana.

The destruction of the concept of controlled drug usage implies that everyone who ever used heroin will be a "dope fiend," everyone who drinks will be an alcoholic, etc. In general this strategy equates the use and abuse of drugs and implies that it is impossible to use the particular drug or drugs in question without physical, mental, and moral deterioration. Such a view holds that there are powers within the drug over which no one can exert control. The extreme absurdity of such a view seems apparent when one considers the vast majority of persons who use alcohol in this country with minimal or no dysfunctional consequences and the numbers of users of illicit drugs who do not suffer physical deterioration, who do not progress to compulsive drug usage, who do continue to work, raise children, and maintain the usually expected social responsibilities. The idea that there are overwhelming powers within drugs is probably nowhere better illustrated than in a statement in Marc Olden's 1973 book, Cocaine, in which he states: "It's possible to get a habit just from handling the drug."[38] The continued belief in this domino theory of chemical progression and its implications for current policies is perhaps well illustrated by a 1974 survey in which 39 percent of non-marijuana users in the sample cited "marijuana use leads to harder drugs" as the primary reason for their opposition to legalization of marijuana[39]

The Drug Is Associated With the Moral Corruption of the Young, Particularly Their Sexual Corruption

Chemicals have long been inextricably linked in prohibitionist literature with the sexual corruption of young people. Joan Fran Rauch attacked chocolate in 1624 as a violent inflamer of passions,[40] tobacco was linked with sexual immorality in the 1850's [41] and the association between opium and the corruption of young women in the 1880's with the publication in 1882 of H. H.

Kane's Opium Smoking in America and China in which Kane states:

> *Many females are so much excited sexually by the smoking of opium during the first few weeks that old smokers with the sole object of ruining them have taught them how to smoke. Many innocent and over-curious girls have been thus seduced*.[42]

It has already been outlined how cocaine was extensively associated with sexual attacks on white women by black men during the early 1900's. During the alcohol prohibitionist movement era alcohol was reported to create sexual excess within and outside of marriage, and alcohol was subtly webbed through stories of Jews "buying up the virtue of Gentile virgins" or Roman Catholic priests "seducing Protestant girls in nunneries."[43] In an expose of the white slavery traffic written in the 1930's, we find the arch villain (the alleged pimp) responding to a question on how he procures women for the life of prostitution:

> *I secured a large number of girls from high schools, by doping them with my weed*.[44]

There is an added irony on the above theme that occurs as one reads through the prohibitionist literature from different periods. Nearly every drug that has been singled out for prohibition (opium, cocaine, alcohol, marijuana) has been said to provoke uncontrolled sexual desire and provoke sexual attacks upon defenseless women while at the same time the drug is said to produce impotence.

The media coverage of the numerous lifestyle changes of the 1960's constantly associated drugs with communal living, cohabitation, etc. Pictures of teenage girls allegedly prostituting to "support their habits" blazoned across the television screen did nothing but update this age-old association between chemicals and sexual corruption. The inflaming of this fear about the fate of our own children made it difficult if not impossible for most Americans to take a careful and reasoned look at our drug policies.

Both User and Supplier Are Defined as Fiends, Always in Search in New Victims: Usage of the Drug is Considered "Contagious"

The prohibition propaganda which has surrounded the presently illicit drugs represents a blatant manipulation of the symbols of evil that would do credit to Jonathan Edwards. Nothing can so excite an adult population as can anything which appears to threaten their own children. Since the Harrison Act of 1914, the user and the seller of illicit drugs have both been characterized as evil, criminal, insane, and always in search of new victims, the victims are characterized as young children. Drug usage is characterized as "contagious;' its increase (real or imagined) is characterized as an "epidemic." Efforts to reduce drug usage are referred to as the "war" on or "battle" against drug abuse. Person who sell are called "pushers" in spite of increasing evidence that most persons get drugs, particularly their first drug, from friends and not some arch villain who seduced them on a street corner.

Policy Options are Presented as Total Prohibition or Total Access

Prohibitionists have always characterized themselves as being in a moral/religious battle against evil. This quality of the prohibitionist movements eliminated the option of compromise. The choice as they saw and presented it was total prohibition or total access to the hated drugs. It was not the other methods of controlling use did not exist or would not work; it was the idea that all usage was sinful and must be stopped. Like an ongoing morality play, this same issue gets played out repeatedly today with a new cast of characters. As bills are introduced to lower criminal penalties for various illicit drugs, one can anticipate any number of legislators

standing to attack reduced penalties as an invitation for use and a first step toward legalization of drug X.

Anyone Questioning Any of the Above Assumptions is Bitterly Attacked and Characterized as Part of the Problem That Needs to be Eliminated

A reading of any number of works which trace the development and evolution of our narcotics policy, all demonstrate the personal hazards in challenging those policies. To attack or challenge existing policies has opened one up for charges ranging from a lack of patriotism to charges that the critic is himself part of the international drugs conspiracy. To most persons, confronting the issues surrounding the inadequacies of existing drug policy is simply not worth the challenges to their own personal integrity.

The Prohibitionist Legacy

The prohibitionist themes as outlined above have left a burdensome legacy that severely limits any attempt to more adequately and rationally address the control of chemical mood alteration in our society. Consider the following:

1. American policies continue to be organized around the notion of "good and bad" drugs, although good and bad may be couched in terms like "safe," "dangerous," "schedule I," "schedule II," and so forth. Our preoccupation with chemistry has prevented us from focusing on the excesses of the behavior. The question is not how do we prevent people from using "bad" drugs - we cannot. The question is how to provide social structures and rituals which decrease the excesses of usage of all drugs and the subsequent high personal and social cost of such extremes.

2. Our prohibitionist legacy has left us without a commonly understood language to address the excessive use of all mood altering drugs. We are left instead with an emotionally loaded language that continues to channel our thinking into good and bad drugs. A person receiving opiates under a doctor's care is a "patient," a person using opiates without medical supervision is a "drug addict," a person receiving amphetamines from a doctor is under "medical treatment," a person using the same amount of amphetamines without the doctor is suffering from "drug abuse,' a physician prescribing drugs is a "healer," a non-physician distributing the same drugs is a "pusher." Chemicals received from doctors are "medicine," the same chemicals received on the street are "dope." A person abusing illicit drugs is an addict, a junkie, a hype, a freak, an acidhead, a pothead, etc. A person abusing nicotine is an ___?___(no word in language), a person abusing caffeine is an ?___(no word in language); a person abusing alcohol is suffering from the "disease" of alcoholism. To be using drugs is to be "dirty," to be free of drugs is to be "clean."

3. The good and bad drug dichotomy has also resulted in an artificial dichotomy in the prevention and treatment field. There is an alcoholism prevention/treatment field and a drug (primarily illicit) drug abuse prevention/treatment field, with neither field addressing in any significant manner the treatment of excessive use of prescription drugs, over-the counter medication, tobacco, etc. or addressing adequately the now large group of clients who are abusing both alcohol and other drugs either concurrently or sequentially.

4. The anti-hedonistic and abstinence stance of the prohibitionist has also influenced our treatment approaches. If one looked at the amount of energy in the 1960's which went into explaining that methadone did not produce euphoria, you would think a cardinal tenet of treatment was that it could not be pleasurable. Treatment has also been consistently defined as "good" only to the point that it produced total abstinence from all psychoactive drugs--a policy which continues to define methadone maintenance clients as second-class citizens on the basis of a criterion that the majority of Americans could not meet.

5. Our preoccupation with "bad/illicit" drugs continues to detract our attention from the overall extent of prescribed psychoactive drug use and the increasing practice of self medication in our culture. If one could step into the future and look back on the major developments in chemical mood alterations, the use of illicit drugs would appear insignificant to the increased usage of approved over the counter and prescribed mood altering drugs.

6. The rigid moral principle of abstinence, the basis of prohibitionist thought, has spawned an equally rigid anti-prohibitionist movement. Where the former saw drugs as totally evil, the latter does not address the real dangers in excessive drug usage. Where the prohibitionists have demonized the drugs, the users, and the sellers; the repeal advocates and reformists have often demonized the laws and those who represent and enforce them. Where the prohibitionists have implied that many of society's problems will disappear with effective prohibition; the advocates of repeal imply that most, if not all, of the "drug problem" will disappear with legalization. Where the prohibitionists see the spread of drug use as part of a conspiracy of a foreign enemy; those for repeal tend to see the spread of drug control lass as the product of an internal conspiracy. Both view our present situation in simplistic terms which totally obliterate the extreme complexity of the issues surrounding the control of chemical intoxication within a heterogenous and rapidly changing culture. There is grave danger is this either/or polarization that is beginning to take shape. Although it is important to acknowledge that our past moral inflexibility has prevented us from accepting potentially effective strategies which could be construed as sanctioning illicit drug use, we must equally acknowledge that the abdication of all controls would not improve our current situation.

7. The continued association between crime, insanity, sexual corruption, miscegenation, evil conspiracies, etc. and illicit drugs makes rationally proposing policy alternatives politically risky for anyone in a position to have those alternatives heard.

CONCLUSION

A powerful system of prohibitionist beliefs and fears about the currently illicit drugs has been woven into the very fabric of our culture. It is this system of beliefs and moral premises, much more so than our technical capabilities, which severely restrict the development of more enlightened social policies on the excessive use of mood altering drugs.

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A History of Adolescent Alcohol, Tobacco and Other Drug Use in America[1]

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The approach of a new millennium invites reflection into our past and speculations about our future. This paper will detail the evolution of adolescent alcohol, tobacco, and other drug (ATOD) use in America and identify those factors that have and will likely continue to influence the rise and fall of adolescent ATOD use.

I. ATOD Use in Native and Colonial America

At the time of European contact, Native American tribes had an extremely sophisticated knowledge of botanical psychopharmacology and utilized a wide spectrum of psychoactive drugs within Native medicinal and religious rituals. Native children had cultural access to such drugs only within the framework of such rituals. There is little early evidence of secular or recreational drug use or misuse among Native American tribes until distilled alcohol came to be used against them as a tool of economic, political and sexual exploitation (MacAndrew and Edgerton, 1969; Mancall, 1995; Westermeyer, 1996).

Europeans brought to the Americas a taste for alcohol and a comparatively limited knowledge of psychoactive medicines. Alcohol was the "Good Creature of God"--a gift from the Almighty that was integrated into nearly every aspect of Colonial life. Men, women and children drank alcohol daily, not so much from a desire for alcohol's

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intoxicating effects as it was the lack of alternative liquids. Contaminated water that could and did spread lethal disease earned alcohol its designation as aqua vitae--the “water of life” (Vallee, 1998). Children (even infants) were provided warmed alcohol (usually in combination with bread or other food), and young boys entered taverns to be taught by their fathers the arts of storytelling and drinking (Rorabaugh, 1979; Steinsapir, 1983). While alcohol was valued in Colonial America, drunkenness was highly stigmatized as a sinful misuse of this gift from God. While many pre-revolution laws were passed to prevent drunkenness in the Colonies, there is little evidence of special concerns about limiting the age of access to alcohol. When age ordinances did begin, they usually restricted access to alcohol for those under the age of sixteen (Mosher, 1980). Well into the late 1700s, drinking by students and faculty was an accepted and expected part of American campus life (Brown, 1966; Warner, 1970).

Slave Codes denied Americans of African descent access to alcohol, but many slave masters practiced a ritualized degradation of slaves with alcohol during holidays. There is no evidence of drinking by slave children, and African slaves were as a whole such a sober people, that they were long thought to be immune to the effects of alcohol (Douglas, 1855).

II. Growing Concerns about Juvenile ATOD Use in the Nineteenth Century

America went on an extended drunken binge in the post-Revolutionary War decades. Annual per capita alcohol consumption tripled, drinking tastes shifted from fermented alcohol to distilled alcohol, the colonial tavern (a symbol of community health and hospitality) gave way to the urban saloon (a symbol of drunkenness, vice, and political corruption), and moderate drinking within a family context shifted to excessive drinking by unattached and socially disruptive males. These alarming changes incited a century-long temperance movement whose goal was nothing short of completely banishing alcohol’s threat to children, families, communities, and the country (Cherrington, 1920; Lender and Martin, 1982; Rorabaugh 1979).

The temperance movement forced a cultural reassessment regarding children and adolescents’ access to alcohol and tobacco. Local and state laws were passed in the second half of the 19th century that required temperance education in all public schools and prohibited the sale of alcohol and tobacco to those under the age of first 18 and later 21 (Mosher, 1980). Children and adolescents were enlisted in the temperance movement (the “Children’s Crusade”), and special branches of temperance reform clubs were organized for adolescents and young adults experiencing alcohol-related problems (White, 1998). Not surprisingly, colleges and universities began to alter their previous tolerance and promotion of alcohol on campus (Warner, 1970).

In spite of lurid journalistic tales of children seduced into the doorways of opium dens, there is little evidence that adolescents were involved in any widespread drug experimentation during the 19th century. There were, however, concerns about the growing exposure of infants and children to drug-laced medicines and tobacco. Opiate-laced preparations in products like Children's

Comfort and Mother Bailey's Quieting Syrup were so popular for calming infants and children that warnings began to appear about the deadly possibilities that could accompany their use (Haller, 1989; Pollard, 1858). By the late 1900s, reports of neonatal narcotic addiction also began to appear that were the result of maternal opium use during pregnancy and while nursing (Fischer, 1894; Mattison, 1896).

III. Juvenile Narcotic Addiction and Alcohol/Drug Experimentation during the Prohibition Years

The 20th century opened with the culmination of decades of anti-alcohol and other anti-drug movements. These now mature movements used the vulnerability of youth as an ideological platform to support a ban on the non-medical use of narcotics and cocaine (1914) and the non-medical and non-religious use of alcohol (1919). Following implementation of these laws, illicit alcohol and drug cultures emerged. Youthful experimentation with alcohol, tobacco and other drugs became a sign of chicness and independence within these cultures. Particularly alarming was the first significant episodes of juvenile narcotic addiction.

The 19th century profile of opiate addiction--that of women addicted to opium or morphine as a consequence of medical treatment--gave way in the early 20th century to young males seeking not relief from pain but pleasure from a newly released narcotic, heroin. Heroin use rose among the children of first generation white immigrants who were crowded within the slums of America's largest cities. Explosive immigration, urban poverty, and the breakdown of country-of-origin cultural and family norms all played roles in the rise of early 20th century juvenile narcotic use. Drug use became ritualized within newly emerging drug cultures that offered a haven to youth who, whether by choice or exclusion, had become detached from the broader culture (Courtwright, 1982).

Following the repeal of the Eighteenth Amendment in 1933, alcohol and tobacco were destigmatized and then glamorized--in fact, ceased being viewed as "drugs," while use of other drugs became increasingly criminalized. The wounded anti-alcohol and anti-tobacco movements retained only enough power to pass age limits on alcohol and tobacco--an effort that succeeded in part by arguing that there was a direct link between tobacco and early alcohol use and juvenile delinquency (Gehman, 1943). The late 1920s and 1930s saw new youth-oriented anti-drug campaigns launched that led, in 1937, to marihuana being added to America's list of prohibited drugs.

The marijuana plant had long been used in America for its fiber, and cannabis tinctured in alcohol had been used in 19th and early 20th century medicine--even as an adjunct in the treatment of alcoholism and narcotic addiction. Its use as an intoxicant in the U.S. was introduced by a young school teacher, Fitzhugh Ludlow, who wrote of his experiments with the drug in his 1857 book, *The Hasheesh Eater*. While there followed periodic journalistic exposés of "hashish houses" in the 1870s, the drug remained relatively invisible until its use rose during the 1920s. It was in this period that marijuana became linked to Mexican migrant workers at a time of growing racial and class conflict in Southwestern United States. The anti-

marihuana campaign of the 1920s and 1930 linked the drug to crime, violence and insanity and portrayed young people as exceptionally vulnerable to the drug's effects (Anslinger and Cooper, 1937; Rowell, 1937, 1939). There is little evidence of widespread youthful marijuana experimentation during the 1920s and 1930s, but the prohibition of Marijuana in 1937 would eventually have an enormous effect on young people in America. As a newly classified "narcotic" under federal statute, all subsequent laws that increased the penalties for possession of narcotics were applicable to marijuana. This led to a situation where many young people in the early 1960s found themselves facing draconian sentences that in some states included the possibility of life imprisonment for possession of small amounts of marijuana (Bonnie and Whitebread, 1970; Musto, 1972).

The anti-marihuana campaign of the 1930s gave way to good news in the 1940sBa dramatic decline in narcotic addiction during World War II. While this decline precipitated predictions that America's drug problems were on the verge of being solved, events in the early 1950s quickly dashed those hopes (Musto, 1974).

V. Mid-Twentieth Century Polydrug Use: 1950-1980

As illicit trade routes were re-established following World War II, a new epidemic of juvenile narcotic addiction unfolded (Chein, 1956). Admissions of person under age 21 to the two federal narcotics hospitals rose from 22 in 1947 to 440 in 1950 while juvenile narcotic arrests in New York City rose from 33 in 1946 to 775 in 1951 (Conferences, 1953). There was also a marked a change in the ethnic composition of America's young addicts. The incidence of heroin addiction among young African Americans and Latinos exploded in the 1950s as minority neighborhoods--the same neighborhoods that witnessed white ethnic narcotic addiction at the turn of the century--were flooded with cheap heroin (Helmer, 1975). Concerns about the growing heroin epidemic triggered harsh new anti-drug laws whose provisions included the potential for life sentences or the death penalty for anyone selling drugs to a minor.

In perhaps the first roots of a rising polydrug phenomenon, the 1950s also saw the first reports of youthful inhalation of volatile solvents for purposes of intoxication (Clinger and Johnson, 1951) and the first reports of a rebellious clique of young chain-smoking, hard-drinking artists and writers (known as the "beats") whose challenges to conventional society sometimes included marijuana experimentation. The Beats were a cultural marker of things to come.

The 1960s and 1970s witnessed America's first widespread youthful polydrug epidemic. Marihuana, and to a lesser extent LSD, became sacraments within a drug-experimenting youth subculture that by the 1970s usually involved alcohol, cannabis and an assortment of newly popular hallucinogens (PCP), stimulants, barbiturates, and "look-alike" drugs. This period was marked by an increased perception of marihuana as a relatively benign drug, a growing acceptance of marihuana use, and proposals for decriminalization of marihuana coming from the highest levels of government. The year 1979 was the high-water mark for 20th century adolescent illicit drug use

with 30.9% of 12-17 year old youth and 60.4% of high school seniors reporting having used marihuana sometime in their life (Monitoring, 1996). Masked within this illicit drug experimentation were changes in youthful licit drug consumption. Concern about illicit drugs gave smoking and drinking a benign mask that triggered as much parental relief (that their kids weren't using "drugs") as alarm. Hidden behind headlines about new and exotic drugs was the cold reality that an inordinate and growing number of young people were killing themselves and others in alcohol-related traffic fatalities and were not heading the warnings about tobacco to which there their parents were beginning to take notice.

VI. Late Twentieth Century ATOD Use Trends

There are two discernable changes in adolescent ATOD use in the closing decades of the 20th century. The first period from 1981 to 1991 was marked by declining daily, monthly and lifetime illicit drug use by adolescents at all grade levels surveyed, a parental backlash against drug tolerance, intensified prevention campaigns targeting marihuana, a repeal of many early marijuana de-criminalization experiments, and a growing stigma associated with illicit drug use. While the overall pool of illicit drug consumers was shrinking, there were concerns about changing patterns of use. Great alarm was expressed over the rise in cocaine use during the 1980s and, in particular, the use of crack cocaine by adolescents. There were also concerns about the lowered age of onset of alcohol, tobacco and other drug use. But all of this was overshadowed by what some called a new era of temperance in America.

A second period emerged when the decline in overall drug experimentation began to reverse itself in 1992 and rose significantly until 1996 and then reached plateaus in 1997 and 1998. While middle and upper class cocaine use leveled off, there was growing concern that crack cocaine use was becoming endemic within America's most disempowered communities. There was also resurgence in polydrug use (marihuana, hallucinogens, solvents, amphetamines), and a rise in heroin use triggered in part by increased heroin purity and a resulting shift in method of ingestion from injection use to intranasal use (Monitoring, 1998; White and Webber, 1999). Resurging adolescent drug use is likely to once again capture, at least briefly, the attention a nation that is weary from a century of drug epidemics to which there seems to be no end and no solution.

VI. Adolescent ATOD Trends: The Big Picture

Let's see if we can step back from this briefest of sketches to explore in more depth what the most important themes are within the evolving history of adolescent ATOD use in America. The psychoactive drug menu presented to adolescents has continued to increase in number and variety of drugs. Illicit drugs have become more potent and more accessible to adolescents. Drug choices have continued to evolve with alcohol, tobacco and marijuana being the modern baseline drugs of choice for young drug users. The price-per-unit of some drugs has recently changed in ways that increased their accessibility to young

people, e.g., crack cocaine. Most adolescents today are more likely to procure drugs from another adolescent than an adult. Adolescents today are more likely to be prescribed psychoactive drugs by a physician/psychiatrist than at any previous period in American history--drugs that can be potentially abused or diverted into the illicit drug market.

The characteristics of young drug consumers have evolved throughout the 20th century. Young men have become more vulnerable to illicit narcotic use, and young women are more likely to be involved with alcohol, tobacco, and illicit non-narcotic drugs. Young people of color are much more vulnerable to the misuse of alcohol, narcotics and other illicit drugs compared to a century ago when such use was virtually nonexistent. By far the most significant change in characteristic of drug consumers is the lowered age of onset of regular alcohol and other drug exposure. For 150 years (1820-1970) America successfully postponed the age of onset of regular ATOD exposure until after the biological changes of adolescence. Between 1970 and 1990, that achievement was lost. A majority of adolescents entering addiction treatment in the 1990s reported pre-adolescent onset--perhaps adding confirmation to the findings of a just-completed study that found a direct relationship between early onset of use and increased risk of lifetime incidence of addiction (Dennis, et. al., 1998).

The physical, psychological, social and legal context of adolescent drug use has changed. The location of use has shifted from the home to the wider community. The motivations for drug use have also changed through this history from that of relief of physical pain to a search for pleasure and the use of drugs as a socially or politically symbolic act. The social setting of use has shifted from the family to one's generational peers. This century generated a highly organized youth-oriented drug culture with its own language, values, rituals, symbols, music and dress. This culture may be as attractive to some adolescents as the drugs that can be found within that culture.

Adolescent drug use has moved from a licit to an illicit activity within the space of a single century. The resulting illicit drug culture has been recently transformed under resurgence of cocaine use, leaving young people who drawn to this culture more likely to be both perpetrators and victims of drug-related crime and violence. A final and dramatic recent change in the context of drug use is the emergence of injection drug use and sexual contact with injection drug users as the primary risk factors related to HIV transmission in America. HIV/AIDS has fundamentally changed the context of illicit drug use in the United States and the vulnerabilities adolescents face in experimenting with illicit drugs.

The Coming Century

ATOD use has long had multiple effects upon, and meanings to, adolescents. There are many factors that will continue to make adolescents particularly vulnerable to the untoward effects of these substances: low tissue tolerance, inexperience and poor judgment, responsiveness to peer coercion, a propensity for impulsivity and risk-taking, and a tendency to embrace drug use as ritualized affirmation of the transition from childhood to adulthood.

Juvenile drug use in America rose in tandem with a weakened nuclear family structure, decreased contact between youth and extended families and kinship networks, the dissipation of value-homogenous neighborhoods, the emergence of peer-oriented surrogate family structures, and the targeting of young people by licit and illicit drug industries. These ecological influences will continue to exert an enormous influence on adolescent drug use in the 21st century. The coming century will challenge us with new and more potent psychoactive drugs, drugs that enhance various aspects of human performance, more efficient methods of drug administration, and the emergence of drug cocktails (precisely mixed drug combinations) that will challenge two centuries of research and control policies that focus on each drug in isolation. The 20th century trend that will have the greatest impact on the 21st century will be the dramatic lowering of age of onset of alcohol and other drug exposure. No change of the past 200 years has more profound and potentially enduring effects.

Our prevention and intervention technologies must evolve in anticipation of, and in tandem with, changes in the psychoactive drug menu, changes in the characteristics of adolescent drug consumers, and changes in the ecology of adolescent drug use.

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The Legalization Debate: Is there a Middle Ground?

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The legalization debate today is very different from when it began with the hearings for the Marijuana Tax Act of 1937 that effectively made it illegal through high taxation. In the 17 years prior to the act, only seven articles were listed in the Reader's Guide to Periodic Literature and the main concerns expressed at the time were that a) farmers would be inconvenienced by having to kill a plant that grew wild in many parts of the country, b) domestic hemp industries would be damaged, c) paint and varnish companies would have to find a new source of oil (then obtained from hemp seeds) and d) impact of having to remove hemp from bird seed on "singing birds" (Bonnie & Whitebread, 1970). Most of the information presented against marijuana was hearsay about how it turned people into murderers and would be used by the underworld to enslave youth, or it was tinged with anti-Hispanic tones about migrant workers (Sloman, 1979). In the ensuing years there has been a near continuous and highly polarized debate concerning marijuana. Policy arguments have and often continue to be framed at the extremes of draconian prohibition/criminalization on the one side and unfettered legalization/miracle cure plant promotion on the other. Today, marijuana is both the most commonly-used illicit drug (suggesting many people do not agree with or care about the risks) and the illegal drug most likely to be mentioned in arrests, emergency room admissions and autopsy reports (suggesting that it is not the harmless substance proclaimed by its proponents). In this chapter we will attempt to contrast the major arguments being made by both sides and explore whether there is any middle ground in the continuing debate over the legal status of marijuana in the United States.

Themes Around Which the Debate and this Article are Organized.

Even a cursory review of marijuana policy discussions leads to the conclusion that this is a debate of extremes: soft versus hard drugs, good versus bad drugs, supply reduction versus demand reduction, miracle drug versus carcinogenic, prohibition versus legalization. It is also apparent that the debate is often conducted with code words that say as much about issues of social class, race, gender, generation, and institutional self-interest than about drugs and drug policies. Complicating matters further, both sides of the debate consider the status quo unacceptable and seem to use some of the same data to reach radically different conclusions. Table 1 provides a summary of some of the main themes in the debate and highlights some of the arguments being made on both sides. The chapter is organized according to these themes, and in each section we attempt to summarize the argument on each side and then present our

understanding of the middle ground. Taking all of the information together, the final section summarizes the implications for policy makers and presents our recommendations.

Table 1. Summary of Main Themes in the Marijuana Legalization Debate

	Common Proponent Arguments	Common Opponent Arguments
Right to Use	• Individuals should have the right to decide whether to use marijuana just like cigarettes or alcohol. • There is a large minority that has and continues to use marijuana and should be allowed to do so as long as they are not harming others.	• Most addictive substances are not legal because they hurt the individual and society -- particularly adolescents.
Alternative Uses	• Marijuana may have important medicinal value and/or help relieve symptoms during chemotherapy. • Hemp can be grown for commercial use with such a low THC level as to have minimal illicit value. • Hemp could be a commercially viable alternative to tobacco for small farmers.	• Alternative and more effective drugs exist for the same purpose. • There are alternative fibers for the same purpose. • The commercial market for hemp is small. • Hemp might be diverted to the illegal product of marijuana.
Consequence of Use	• There are no to minimal consequences of marijuana use. • Many of the consequences that do exist are artifacts of the current laws (e.g., possession). • Marijuana use is not associated with property crime or violence and is thus more like alcohol and tobacco than like cocaine or heroin. • Dismiss claims of consequences as "myths" or propaganda.	• Increasing marijuana use is associated with increasing rates of dependence on marijuana, tobacco, alcohol and other drugs, particularly among adolescents. • Increasing rates of marijuana use are associated with a wide range of other legal, social, emotional, and health problems. • Marijuana is a known carcinogen and can exacerbate or lead to lung conditions.

Effectiveness of Regulation	• Current interdiction, incarceration, prevention and treatment policies do not work. • Prohibition did not work.	• Current policies are not perfect, but do work. • Prohibition was very effective.
Cost to Society	• Legalization would save enforcement, court and prison costs. • Legalization could be used to generate another sin tax.	• Real costs to society would be in terms of increased rates of dependence and their associated psychological, family and vocational problems. • Other legal costs from increased DUI (from alcohol and/or marijuana), and fights may consume savings. • Cost to adolescents is particularly high.

Right to Use

One of the most fundamental concepts for the proponents of legalization is the idea that individuals should have the right to decide whether to use marijuana just like cigarettes or alcohol. Most recognize that this right would have to be linked to the idea that they are not harming others and that there would have to be some kind of regulation parallel to existing DUI laws and restricted smoking areas due to secondhand smoke. A key piece of information used in this debate is that marijuana has and continues to be the most commonly-used illicit substance in America. In 1996, for instance, 32% of Americans in the household population (50% of those aged 25 to 34) had used marijuana in their lifetime and 5% (6% of those aged 26 to 34) had used it in the past month (OAS, 1997). By way of comparison, the lifetime and past- month rates of using all other illicit drugs (e.g., cocaine, crack, hallucinogens, inhalants, prescription drugs and opioids) were only 18% and 3% respectively. Moreover, the American public perceived the risk of marijuana use as lower than alcohol for both occasional use (44% vs. 54%) and regular use (60% vs. 77%). In addition, preliminary data from the 1997 National Household Survey on Drug Abuse (NHSDA; OAS, 1998) show that the perceived risk of using marijuana has dropped to a 10-year low. Thus, the argument is being made that there is a large minority that has and continues to use marijuana and should be allowed to do so as long as they are not harming others. Moreover, following in the wake of successful referenda allowing limited legalization of marijuana in California and Arizona, there will undoubtably be more efforts in the 21 (mostly western) states that allow this sizable minority to propose voter-initiated referenda. While some will fail, this ad hoc approach to legalization is likely to be a major facet of the political landscape for the foreseeable future.

Opponents of legalization typically argue that most addictive substances are not legal because they hurt the individual and society - particularly adolescents. Moreover, marijuana is a gateway drug that often leads to other drug use and problems (Mustari et al., 1997; Johnson & Gerstein, 1998). The core of this argument is that use is likely to harm the individual or others and hinges largely on the remaining themes below.

While this issue can be informed by facts, the fundamental issue is a question of how the rights of the individual and society can be balanced. Clearly tobacco and alcohol are both harmful substances that we “chose” to keep/make legal in spite of the consequences. Similarly, we have enacted and repeated numerous safety laws based on what we as a society were willing to tolerate (e.g., 55 mph speed limits, mandatory seat belt laws, vagrancy laws). Thus,

we recognize that this is a “value” decision that society must make and that a large minority would like the right to do so. But unlike 60 years ago, this time we need to make a more informed and rational decision. This we have tried to do below.

Alternative Uses

Medical Use. Many of the current ballot initiatives focus less on the overall legalization of marijuana than the legalization of its use in the treatment of people with severe and/or terminal illnesses. Numerous anecdotal reports have been given suggesting that marijuana may be useful in treating nausea and/or stimulating appetite in those undergoing chemotherapy, with glaucoma, or being treated for AIDS. This movement has recently gained significant momentum from meta analyses showing that the application of marijuana’s active ingredient (delta - 9-tetrahydrocannabinol or THC) does appear to be useful in treating the nausea associated with cancer chemotherapy and in stimulating appetite (Voth & Schwartz, 1997).

The argument against the medical use historically has been founded on three principals. First, other drugs that do the same things are available. Second, marijuana is a carcinogen or at least a harmful substance. Third, there has been a lack of empirical studies evaluating marijuana use. While the latter increasingly is being addressed, it is important to note that these studies have produced very mixed results. The Voth & Schwartz (1987) article cited in favor of using pure THC also noted that they did NOT find evidence that the crude form of THC found in marijuana was sufficient to help with side effects and that both pure THC and crude marijuana acted like carcinogenic substances. Moreover, reports that marijuana might also be effective in relieving the side effects of HIV / AIDS treatments and improving appetite have not always held up under more rigorous preliminary examination (Whitfield, Bechtel, & Starich, 1997).

We believe that there is sufficient anecdotal and scientific evidence to support further research on the effectiveness of marijuana in the treatment of seriously and terminally ill patients. However, evidence on marijuana’s effectiveness and safety is very mixed, and problems have been reported. In particular, marijuana may cause a variety of respiratory problems and there is some evidence that it is a carcinogenic substance. While this is true of other medications for terminally or severely ill patients (e.g., azidothymidine or AZT), there are scores of examples where a rush to put substances into the market place led to significant negative consequences (e.g., amphetamine diet pills or thalidomide). The medical uses of marijuana and/or pure THC should be evaluated, but with the full set of safeguards expected of any new product (though probably under the fast track regulation given the severity of the conditions in question).

Commercial Use. The second alternative use that is often proposed is the legalization of hemp - a generic name for marijuana plants including those with such low THC levels as to have minimal illicit value. Hemp was one of the first plants cultivated by humans and has been used to make fabric and paper for over 10,000 years. It was grown by Presidents Washington and Jefferson, was a royally- and then federally-mandated crop during the 17th and 18th centuries and was a federally-subsidized crop in the U.S. as recently as World War II. The U.S. government, however, has not issued a permit for growing hemp in 40 years (http://thehia.org/public/hempfacts.html)

Proponents of reissuing permits or deregulating commercial hemp use (summarized here from Roulac, 1997 and http://thehia.org/public/hempfacts.html) “"assert” that hemp has many uses and one of the highest crop values per acre. Hemp seeds are one of the highest sources of essential fatty acids, complete protein (more of the digestible form than soy beans), and B-vitamins, and contain 35% dietary fiber. Its bark produces one of the longest natural soft fibers which is longer, stronger and more absorbent than cotton fiber, and also provides better insulation than cotton. It is important to note that, while almost half of the agricultural chemicals used in the U.S. are applied to cotton; hemp is asserted to grow well without herbicides, fungicides, or pesticides. If true, hemp would be a more sustainable and less polluting source of fiber for paper, would actually be more resistant to yellowing and decomposition, and is able to be recycled more often. Because of its high value per acre and many uses, hemp could be one

of the few products that small family tobacco farmers switch to (in fact many switched to tobacco because hemp was removed from the market). The list of facts about hemp goes on and on like the ad for the hemp industry that it is.

While relatively small, commercial hemp production is on the rise and many countries have lifted previous bans in the past five years. Countries where commercial production is underway or being established include: Australia, Austria, Canada, Chile, China, Denmark, Egypt, Finland, France, Germany, Great Britain, Hungary, India, Japan, Netherlands, Poland, Portugal, Romania, Russia, Slovenia, Spain, Switzerland, Thailand, and the Ukraine (http://thehia.org/public/hempfacts.html). A major reason that production bans are being lifted is because hemp is a cash crop with one of the highest dollar value yields in agriculture: $750-$1,250 per acre for the fiber and another $300 to $487 for the seeds (www.pbmo.net/oxhemp/commo.html). It may also play an important role in efforts by the Robert Wood Johnson Foundation and several southeastern states to find alternative cash groups for small struggling family-owned tobacco farms (Reaves & Purcell, 1996). These families may be locked into tobacco farming because few other crops can pay the ~$3600/acre gross of tobacco. Though this gross yield is much higher, the planting costs for tobacco are about $2,000 per acre and 5 to 10 times higher than those for hemp.

The arguments against commercialization tend to focus on two issues. The first is that the world hemp market has been relatively small for the past 20 years. Some have argued that the high cost per acre might actually work to keep down the demand even if it was commercialized (Bennett, McDougal, & Roques, 1995). While the Hemp Taxation Act of 1933 did put an end to the industry, production of hemp had already fallen off to less than 200 acres in the whole U.S. in the preceding five years because it could not compete with other less expensive crops (e.g, cotton, flax, pulpwood) and/or cheap imports from overseas. When the Japanese overran the Philippines early in World War II, the U.S. military did have 146,000 acres planted (primary for marine rope), but this production died out after the war when hemp was replaced by stronger and less expensive nylon cord. Countries like Mexico that tried to keep their small hemp farmers going actually had to subsidize it (like the U.S. does with tobacco farms) because it was not commercially competitive with other products and/or hemp produced less expensively in some African or South American countries.

A second issue is that marijuana (with a high THC content) could potentially be grown under the guise of being hemp because the plants are almost indistinguishable to the naked eye. This point is not in dispute by anyone and it is relatively clear that the ulterior motive of many people wishing to reintroduce commercial hemp is, indeed, to either get a foot in the door of full legalization and/or provide cover for growing hemp that contains a meaningful level of THC. Opponents maintain that commercialization of hemp is unnecessary because of the available alternatives, and that commercialization has enormous potential to create legitimacy and/or new sources of marijuana at a time when marijuana use is already on the rise.

Like the medication debate, many of the claims about the commercial value of hemp are just that -- claims. If even partially true, hemp could indeed prove to be a valuable commodity. We have significant concerns about its true commercial viability and feel these claims may be grossly overstated. With increased production, the cost of hemp will come down unless there is an increase in demand. It is unclear from where these new markets would come without significant public or private commitments to research and development, and even with these commitments, it is still unclear if costs could be brought down sufficiently to make the products commercially viable alternatives to well-established natural and synthetic alternatives. In terms of public funds, policymakers need to weigh some of the potential advantages (e.g., a replacement crop for small tobacco farmers, a less polluting crop) against the certainty that at least some of the hemp would be diverted into plants with a higher THC level for marijuana use. We believe that agricultural researchers and companies should be allowed to further explore the properties and commercial value of hemp, but that this development needs to be monitored and any commercial production taxed at a sufficient rate to cover the costs of a testing/monitoring program to minimize diversion.

Consequence of Use

Proponents of legalization often explicitly state (or imply) that a) there are no to minimal consequences of moderate marijuana use, b) the problems are no worse than those related to alcohol use, c) many of the consequences that do exist are artifacts of the current laws (e.g., possession), and d) marijuana is not a "hard drug" like cocaine or heroin because it is not associated with property crime, dependence, or health or emotional consequences. Proponents rarely offer more than anecdotal evidence and/or circular claims to support their positions; rather, they often try to argue against "Myths" or propaganda put out by the "opponents" and or the government (e.g., Zimmer & Morgan, 1997, http://www.visi.com/-gm/infocanv/myths.html).

Opponents argue that there is an extensive litany of evils that result from marijuana use and that it is a gateway to heavier drug use. While they are quick to give lists of problems they assert are caused by marijuana, they also primarily rely on anecdotal evidence or circular claims and focus on disproving the "myths" and propaganda of the opponents (vs proving their own point).

Unfortunately both sides often do a poor job of proving their own points or fairly weighing the evidence and instead simply cite their position in an ideological mantra. Complicating matters further, there is clear evidence the government did originally misrepresented the evidence it had against marijuana (Bonnie & Whitebread, 1970) and has repeatedly exaggerated problems (e.g., refer madness's marijuana will make you murder, marijuana will clog up your arteries, marijuana will give you breasts). In a day and age when marijuana use is common, such exaggerated claims are only useful for a short time before they back fire. Now the government's (and many research) statements are routinely dismissed by the proponents even when they are well ground and, conversely, some government officials seem very reluctant to critically questioning the basis the opponent's assertions.

So what do we know? Since it would be both illegal and unethical to randomly assign people to smoke marijuana, much of the evidence concerning its consequences is correlational. This said, there is substantial correlational evidence from large representative samples of an extensive array of negative consequences that vary proportionately with the frequency of use. For instance, among people who have used marijuana in the past year, 40% reported one or more symptoms of dependence (indicating a need for treatment) in the National Household Survey on Drug Use (NHSDA; OAS, 1995). Among those who used 12 or more times in a year, 60% reported one or more of these symptoms. These rates are very comparable to those associated with 12+ days during the past year of using cocaine (26% and 62%) and alcohol (22% and 68%) -- though lower than those associated with tobacco (59% and 76%) (OAS, 1997). Moreover, Table 2 uses data from the NHSDA to show that the relationship between age of onset and having one or more symptoms of dependence as an adult varies significantly by age. Relative to people who start using as adults, those who start using marijuana between the ages of 15-17 are twice as likely to report a symptom of dependence as an adult; those who start under the age of 15 are six times as likely to report one or more symptoms. Note that in both cases this is a significantly higher rate of risk among adolescents than has sparked recent debate about tobacco and alcohol use (also shown in Table 1) and are very large effects in the field of public health.

Probability and Relative Risk of Having 1 or More Substance Disorder Symptoms as an Adult Based on Age of First Use

Substance Used	Age of First Use of Substance (of lifetime users) *					
	Under 15		15-17		18+	
	1+Sx	Odds	1+Sx	Odds	1+ Sx	Odds
Lifetime Tobacco Users (N=10887)	26%	2.00	20%	1.54	13%	1.00
Lifetime Alcohol Users (N=12795)	27%	3.92	15%	2.12	7%	1.00
Lifetime Marijuana Users (N=5847)	24%	5.71	9%	2.16	4%	1.00

There is also substantial evidence that marijuana use is highly correlated with a wide range of other problems. Using data from the NHSDA again, we found that 14 out of 15 adolescents who used marijuana also used alcohol. Those who used marijuana/alcohol weekly were much more likely than non-users in the past year to have had problems related to committing a crime (69 percent vs. 17 percent), attention deficit/hyperactivity/conduct disorder (57 percent vs. 4 percent), being involved in a major fight (47 percent vs. 11 percent), shoplifting (41 percent vs. 4 percent), being admitted to an emergency room (33 percent vs. 17 percent), committing a theft (33 percent vs. 4 percent), selling drugs (31 % vs. 0%), damaging property (31 percent vs. 3 percent), dropping out of school (25 percent vs. 6 percent), being arrested (23% vs. 1 %), and/or being on probation (16 percent vs. 1 percent) (McGeary, Dennis, French, & Titus, 1998). This is very much like other hard drugs and goes well beyond simple possession. Moreover, increases in problems are almost all directly proportional to the frequency of use -- with low-frequency users having more problems that non-users but less than high-frequency users. Finally, marijuana is also a respiratory irritant and carcinogen, particularly when combined synergistically with tobacco use as is commonly done and delivers more than tar to the lungs cigarettes (Roth, Arora, Barsky, Kleerup, Simmons, & Tashkin, 1998; Voth & Schwartz, 1997; Van Hoozen & Cross, 1997 c.f. Sidney, et al., 1997).

Several of the supposed “myths” about marijuana use have been addressed with empirical studies, including: a) marijuana, tobacco and alcohol do appear to be one (of several) gateways to heavier drug use (Johnson & Gerstein, 1998; Mustari et al., 1997); b) marijuana causes measurable physiological, cognitive, emotional and social impairment (Lundqvist, 1995; Millsaps et al., 1994; Pope & Yurgelun-Todd, 1996; Roffman & Stephens, 1997; Solowij, 1995; Solowij et al., 1995a&b), c) THC is fat soluble, trapped in body fat/tissues and released slowly over time (Chaing & Hawks, 1986; Leighty, Fentiman & Foltz, 1976), and d) marijuana use is now the most commonly mentioned substance among adolescents entering treatment, being seen in emergencies rooms, and/or receiving autopsies (OAS, 1995; 1997). Though there is no evidence yet of a specific toxic effect of accumulating THC in the body, it is associated with continuing physiological impairment that has been documented to persist up to six months after the last use among initially heavy users (Solowij, 1995; Solowij et al., 1995a&b). While there are some mixed findings (endemic to observational research), most research to date suggests that more frequent and/or longer marijuana use is likely to lead to dependence and a wide host of

major individual, family and social problems. While proponents may still prefer to legalize marijuana, they need to recognize that it is an addictive substance and that legalization is likely to lead to increased use and to exacerbate a wide range of problems. This is important because many proponents (e.g., Zimmer & Morgan, 1997; http://www.visi.com/-grp/infocanv/myths.html) continue to cling to the belief that all of the problems are little more than propaganda - willingly dismissing correlational evidence much as smokers did throughout the 1960s and 70s.

Effectiveness of Regulations

The proponents of legalization argue that the continued high use and acceptance of marijuana in spite of increased enforcement and penalties is prima facie evidence of the failure of current regulations. They frequently say that America's experiment with alcohol prohibition was an abject failure and cite data showing little or no change in the rates of alcohol use or problems in the years right before and after prohibition "ended." These proponents also focus on claims that prohibition only serves to increase corruption (e.g., Carter, 1992; Nadelmann, 1991, 1992) and these points lead many to say or predict that the other drug prohibition movements will prove to be a failure. They call either for outright deregulation or a shift back to state and local regulations that were more typical until about 60 years ago. Others note that prevalence data is predicted much less by changes in regulation than by changes in "perceived risk" (Harrison, Backenheimer & Inciardi, 1995).

Conversely, opponents of legalization will argue that the continued high use and acceptance of marijuana is prima facie evidence of the need to redouble our prevention, treatment and legal efforts to combat it. They argue that while people "chose" to repeal prohibition, it was actually very effective and cite data from the years right before and after prohibition was "introduced" to bolster their claims (Burnham, 1993; Moore, 1992a). They also acknowledge the role of "perceived risk" and/or "parental pressure" as a protective factor against use (e.g., Mustari et al., 1997).

Such counter claims are among the most perplexing in this debate since both sides are nominally citing the same data. The incidence of marijuana use today is higher than any other illegal substance and rising back toward prior records from the late 1970s (and exceeding them for 8th graders) (Dennis & McGeary, in press; OAS, 1998; http://www.isr.umich.edu/src/mtfL). The current high prevalence rates are like the proverbial glass of water filled to the middle - both half empty and half full. Whether this is cause for deregulation or tighter regulation goes back to the question of where to place the balance between individual freedom and consequences to society.

Regarding the interpretation of the historical effectiveness of prohibition, we believe the problem here is two-fold. First, the proponents and opponents of regulations are looking at different periods of time. Second, we believe that both regulation and prevalence change in response to public opinion (i.e., their correlation is indirect or even spurious over short periods of time). Let's start by looking at alcohol consumption from 1710 to 1975 using per capita alcohol consumption data from Rorabaugh (1976; 1979). Alcohol use actually peaked at a mean annual consumption of 3.1 to 3.7 gallons per person between 1770-1830, fell off to 1.0 to 1.4 gallons between 1840-1900 and then rose again to 1.6 to 1.7 in the 15 years leading up to prohibition. During prohibition the rates dropped off to .6 gallons per person then went back to around 1.1 gallons after it was repealed and rose gradually again to 2.0 in 1975. Thus, the initial passage of prohibition, which coincided with massive public displeasure with the rising rates of alcohol use (as evidenced by passing the prohibition amendment itself in 2/3rds of the states) did in fact precede a large decline in alcohol use. It also proceeded major declines in the number of people seeking treatment for alcoholism and/or alcohol-induced medical disorders (Moore, 1992), as well as the demise of several major treatment organization and prevention movements (White, 1998). Conversely, in the period leading up to the repeal of prohibition, which coincided with increased public tolerance (as evidenced by the prohibition's repeal via an amendment), use and medical problems had slowly crept back up to their pre-prohibition rates and the laws were often going unenforced; consequently, there was little subsequent change when the actual

amendment was nominally repealed. Thus, the problem is that both groups only look at part of the picture and ignore how regulations are only effective when they are reflections of public opinion and being enforced. Since regulation, enforcement and prevalence typically change in response to public opinion, it is important to incorporate the latter into evaluations of regulations (e.g., looking back over longer periods of time, checking trends in public opinion, looking at the degree to which penalties or regulations are being enforced before they are "nominally" added/removed).

This three-way relationship between public opinion, legislation and use can also be seen in reviews specific to marijuana (e.g., Harrison, Backenheimer, & Inciardi, 1995; Inciardi, 1991). The initial rise in marijuana use began in the 1950s and 1960s and peaked between 1969 and 1972. During the latter period, marijuana was nominally put on the same schedule of drugs as heroin and LSD (Controlled Substances Act of 1970) but at the same time 42 states reduced penalties for marijuana possession and it was clearly part of the popular culture of the time. The second peak of use in the late 1970s followed a five-year period during which 11 states decriminalized possession of small amounts of marijuana for personal use and the Carter Administration was seriously discussing legalizing marijuana. This was followed by a barrage of anti drug laws and prevention campaigns and decreasing use in the 1980s. Extending this analysis into the 1990s, we are currently experiencing 12 year record prevalence rates and record incidence rates among 8th graders (http://www.isr.umich.edu/src/mtf/). Moreover, this coincides with decade long trend in which the general public is viewing marijuana as less and less harmful (OAS, 1998) and several states are again looking at decriminalizing some uses of marijuana.

Cost to Society

Proponents of legalization will typically argue that it would literally save the $3-10 billion dollars currently spent on interdiction, enforcement, court and prison costs and that legalization could be used to generate another sin tax that could serve to both regulate consumption and cover the additional costs of treatment (e.g., Friedman & Friedman, 1984; Nadelmann, 1991, 1992). Others focus on the role of drug prohibition in increasing violence, street crime, corruption, and generally supporting the underworld's illegal activity (e.g., Carter, 1992; Schwartz, 1987). Some also argue that the current widespread use of unregulated marijuana actually poses a heath threat because there are effectively no limits on concentration, additives or even the presence of pesticides. Finally, the cost to society of marijuana use is often compared with the much larger costs to society of alcohol and tobacco.

Opponents of legalization will generally concede that the cost of drug prohibition are great but argue that the costs of legalization are likely to be even greater (e.g, Bennet, 1992; Inciardi & McBride, 1991; Moore, 1992b; Wilson, 1992). They point out that during the period after the (re)legalization of alcohol in the U.S. and during the period of legalized heroin prescriptions in the United Kingdom, use of these substance did generally increase over a period of several years (note that analyses showing no effect are typically limited to short periods of time). Opponents say that like most products in the world, the demand for marijuana is likely to be elastic and increase if the cost decreases. (Note that if the taxes on it were set so high to hold the price constant, this would create a new black market and negate any gains from legalization). Further evidence of this phenomenon can be seen in the crack epidemic of the 1980s and early 1990s that was spurred on by costs as low as $5 per rock. Comparisons of the current cost to society of marijuana and alcohol are misleading since the former is currently illegal and the latter legal. This said, it is important to note that the estimated cost to society of alcohol abuse in 1990 was already several times higher that the criminal justice costs at $98.6 billion (Rice, 1993) and is now presumed to be even higher in 1998 dollars (National Advisory Council on Alcohol Abuse and Alcoholism Subcommittee on Health Services Research, 1998). Finally, the cost of adolescent alcohol use is particularly high as it comes at a critical time of development and is associated with a higher likelihood of ongoing problems as an adult (Dennis et al., 1998).

Some of the issues raised by proponents are legitimate as drug prohibition does costs

billions of dollars each year, particularly as a result of state and federal drug laws that have resulted in record high drug-related arrests, court cases, and prison sentences (Inciardi, McBride, & Rivers, 1996). We can and probably should debate the relative merits of different allocations of these funds and look at their impact on the limited resources of our criminal justice system. However, these costs would not simply go away as a result of legalization for several reasons. First, there will be new regulatory costs to address the issues of quality and dosage as well as the likely prevention of underage use. Second, while many people are in drug court for charges related to marijuana use (31 %), the next most common substance related to the charges is actually "misuse" (e.g., DUI, fighting) of alcohol (27%). Even if marijuana was legalized, it would probably still result in many criminal justices costs because a) we are likely to pass laws holding people responsible for misusing it (e.g., DUI laws) and b) the correlation between increasing marijuana use and increasing alcohol use, fighting, behavior problems and a variety of illegal activities discussed above. Compounding matters further, we believe that it is naive to think that full legalization of marijuana (or even just decriminalization) would not lead to increased use. Additionally, general assumptions that marijuana has few direct health consequences needs to be reevaluated in light of the correlation between increased use, lung problems, attention problems, emergency room admissions and treatment admissions. While marijuana is not likely to result in an over dose, it is increasingly showing up in autopsies (particularly among adolescents) and is likely to be indirectly related to death (e.g., driving under the influence). Recent analyses we have done of the NHSDA data show that those reporting one or more symptoms of marijuana dependence are less likely to be working and, those who are working, work fewer hours (Bray, Zarkin, Dennis, & French, 1998). Thus, we believe that legalization may reduce some but not all criminal justice costs associated with marijuana use and that it is likely to dramatically increase other costs associated with health care and lost productivity.

Reprise, Implications and Recommendations

In reviewing the marijuana legalization debate we have concluded that whether or not marijuana should be legal is fundamentally a "choice" that needs to be made between individual liberty and societal costs -- and that this should be an "informed" choice. While many Americans have some first-hand experience with marijuana, there is a significant amount of confusion about its use, consequences and cost to society. Proponents and opponents of legalization make blanket statements that simply cannot both be true and in many cases even cite nominally the same data to support opposite conclusions. In our search for a middle ground we have tried to fairly review both sides and concluded that:

- There is sufficient anecdotal and scientific evidence to support further research on the effectiveness of marijuana in the treatment of seriously- and terminally-ill patients; however, we also believe that it is not a wonder drug/panacea, has significant potential to do harm and should be evaluated within the framework of existing guidelines for new drugs.
- If the claims about hemp's agricultural properties prove to be true, it may be an important crop, but there are major unanswered questions about these properties and the crops' commercial viability relative to alternative crops and synthetic products; while we believe that agricultural researchers and businesses should be allowed to explore these issues, any commercialization program should include a user fee to cover the cost of a THC monitoring protocol to prevent the likely diversion problem it will create.
- There is substantial correlational evidence that the increasing rate of marijuana use is associated with increasing rates of marijuana dependence, other drug use, behavior problems, cognitive problems, health problems and illegal activities (including those other than possession and dealing); Moreover, these problems are significantly worse for adolescents than adults; any discussion of legalization needs to address these issues and should continue exclusions for adolescent use.
- Regulations to control marijuana, alcohol and other drug use have primarily been

effective when they are reflections of public sentiment and enforced; looking over longer time periods and taking into account public sentiment and both federal and local regulation, we believe that regulations have reduced substance use but have not generally eliminated it.

- The current prohibition of marijuana is expensive, but legalization would not eliminate many of these costs and would increase other cost associated with misuse (e.g., DUI), substance abuse treatment, mental health treatment, health treatment, and result in a loss of workplace productivity; fundamentally we also believe legalization would increase demand and the number of active users.

Both sides have some valid point but also need to recognize some problems in their own argument and approach.

We believe that proponents will continue to argue for decriminalization and legalization of some or all uses of marijuana, but they need to recognize that it does indeed have negative consequences and will probably increase costs to society not reduce them. A serious effort in this vein needs to surpass libertarian issues and address practical questions about dose, quality, regulation, misuse legislation, etc. (See other chapters of this volume). Proponents must also recognize that large numbers of people are already dependent on marijuana and need treatment. Unfortunately, there are no major self-help groups (e.g., AA, CA, NA) or treatment modalities that focus on marijuana use and little research on the effectiveness of current approaches for other drugs apply to this more general population (Roffman & Stephens, 1997)

Opponents of legalization must come to terms with the fact that many of their past claims have indeed been exaggerated. While this might have worked in the 1930s when few people were familiar with marijuana, today the material that was used then is now viewed as “satire” by a more educated public (e.g., the movie Reefer Madness). Opponents also need to move away from general statements (e.g., just say no) or exaggerated claims and focus on the true consequences of marijuana use, much as is done with alcohol and tobacco. General prevention efforst would also be wise to shift from their narrow focus on harder drugs (e.g, heroin, cocaine, crack) that are rarely used, to marijuana -- which is used by more than twice as many people as all the other illegal drugs combined.

According to the most recent national survey (OAS, 1998), by 1997 marijuana had been used one or more times by 33% of Americans over the age of 12 (~71.1 million people) with significant variation by age: 12% of those aged 12-15, 33% of those aged 16-17, 41 % of those aged 18-25, 48% of those aged 26 to 34, and 39% of those 35 or older. Moreover, about one out of seven of these lifetime marijuana users (-11.1 million people) have used marijuana in the past month, with virtually all of these past month marijuana users also using alcohol and one-third using other illegal drugs. In spite of the evidence reviewed above, people are increasingly viewing marijuana as less and less harmful. If they are to make an informed choice the debate must move away from its current ideological basis and do a more fearless appraisal of the actual evidence.

Both sides also need to be careful to look separate at the issues related to adolescent use and even the consequences of their debate. This is the third major period in which our nation has debated decriminalization and/or legalization: each time this has been associated with increased use and decreasing ages of first use. Parental ambivalence about marijuana use (common among baby boomers who feel hypocritical since they used) is statistically the equivalent of telling kids to “go for it.” Unfortunately, the consequences and cost of adolescent initiation (particularly among those under age 15) is significantly higher than it was for their parents (who did not generally start it until they were adults). Both policy makers and researchers also need to recognize the almost complete co-occurrence of alcohol use (and to a lesser extent tobacco use) among marijuana users. The effect of these two or three substances taken together may be very different than studies of just one of them taken alone and needs to be studied.

Conclusion

Robin Room (1978) has argued that social policies toward intractable problems -- and the ownership of intractable problems that flow from these policies -- are inherently unstable. That instability derives from an ever-changing status quo that everyone associated with the intractable problem finds unacceptable. This clearly describes the current debate over marijuana legalization. Marijuana is neither a wonder drug nor the root of all evil. It is widely used, has some viable uses, has some negative consequences and will have substantial costs to society whether it is legalized or not. As we move toward a period of local variation in regulations, the single most important thing we need to do is adopt what the late Donald Campbell (1969) referred to as "an experimental approach to social reform." This means that while strategies for problem resolution may vary in response to rigorous evaluations that determine precisely which policies and programs do and do not ameliorate the problem, a commitment to the seriousness of a particular problem must be unwavering. We suggest that the exploration of any alterations in drug control policy be based on the following foundation.

- The strategy option must be explicitly and meticulously defined, with particular focus on both the goals to which the policy is directed and the means by which those goals will be achieved. Its consideration must be weighed not in the abstract but in the details.
- Establish credible baseline data regarding cannabis use and personal and social consequences of cannabis use prior to policy implementation that will make it possible to measure changes that accrue from various policies and policy enforcement variations.
- Prior to its implementation, identify and measure those variables that could influence (confound) the outcome of the policy experiment.
- Implement systems of evaluation prior to policy implementation. We need to clearly define: "How will we know if this policy is or is not working? What measures will be used to evaluate the success or failure of the intervention?" Every effort should be made to protect data collection and evaluation from corruption by those whose personal or institutional interests are served or threatened by the policy.

As the dialogue regarding the need for any policy changes and the needed direction of those changes moves from narrow academic and policy circles to the mainstream citizenry (via referendum and increasing public attention), there is a growing need for more objective analysis of the facts. While government has a major role to play in this process, it also needs to recognize that its credibility has been compromised with many and needs to consider working with other arbitrators to facilitate a broader discussion (e.g., Robert Wood Johnson, 1998).

We believe that the general citizenry would be willing to tolerate legalization, if it perceived marijuana as something that only had direct effects on an individual, but would not be willing to tolerate it if it had direct effects on other individuals in terms of use (e.g., second-hand smoke) or misuse (e.g., DUI). Most people are willing to endorse medical or commercial research and we recommend this as long as it is well designed and controlled. But the willingness to fully legalize marijuana is likely to be significantly hampered by the growing body of evidence that it does have consequences for the individual (e.g, dependence, cognitive impairment, dropping out of school, emergency room admissions, other drug use), consequences for others (e.g., behavior problems, fighting, theft), and that while some criminal justice costs might go down, some will not and other costs to society are likely to rise (e.g., substance abuse treatment, health care, lost productivity). We, therefore, do not recommend that actual marijuana use be legalized until these issues are better understood and that active steps be taken to try to reverse the current tide of adolescent marijuana use. On the other hand, we do not believe that the punishment for using marijuana should be worse than its consequences. In the hysteria over cocaine, possession of ounce could lead to jail terms worse than for rape or murder. This is out of proportion and not very constructive for the several million people who already are addicted to marijuana. There needs to be balance here as well.

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Gender differences in the severity and patterns of victimization among adolescents treated for substance abuse: Intake status and outcomes

Chestnut Health Systems

Abstract

This article uses data from the Global Appraisal of Individual Needs (GAIN) on 214 adolescents entering substance abuse treatment. The goals of the article are to validate the General Victimization Index (GVI), examine its relationship to gender and co-occurring problems, and determine its relationship to outcomes. The GVI includes 15 items on lifetime traumatic events, traumagenic factors, and current worries of victimization. The items fall along a severity dimension ($\alpha = .88$), and evidence was generated to support the construct validity of cutoff scores for interpretation. Girls were significantly more likely than boys to have experienced a variety of victimization incidents. When used as grouping variables, gender and severity of victimization significantly interacted with measures of intake status and were significant predictors of 3-month postdischarge treatment outcomes.

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 <u>what</u> the Project SAFE was able to achieve, this report attempts to describe <u>how</u> 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

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

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 sited 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.

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

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 problem 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.

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

- 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

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

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 colocation, through the informal modes of colocation 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 colocation exists (and formal colocation 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 colocation, certain conditions must be in place to render the colocation 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

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[1] 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[2] 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

[1] POS (purchase of service) agencies are those that provide child welfare services under contract to DCFS
[2] 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 Sate 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, 2nd 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.

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.

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;

- 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:

  - 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.

Martial 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

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 8th 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 to 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/ Other Stimulants	3.9%

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 interviewing 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 lead 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

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 Alatots). 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.

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 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.

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 l 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.

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

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 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:

- 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.

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.)

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:

- 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 12th 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,"[1] while 2.7 percent of females and 8.7 percent of males report "heavy drinking."[2] This gender discrepancy is most pronounced among those 26 and older, and decreases steadily as age

[1] 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.

[2] 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,[3] 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).

[3] 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; Griifin, 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 symptomotology 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; Hesslebrock, 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 that 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 like 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 on-going recovery efforts (Lex, 1994). It should not be surprising, then that unmarried women have better post-treatment recovery rates than those who are married (McCrady 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 co-morbidity, 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 pattern)(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 (Wilsnak, 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, DiClimente 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[4].

Effects of Partner Violence on Children

[4] 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 (Christopherpoulos 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 anomolies (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[5] (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[6] (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

[5] 200 grams is slightly less than one-half pound
[6] 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: distrusting, 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,
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(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 lighting 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 inter-dependence. 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

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

	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.



Selected Papers of William L. White

www.williamwhitepapers.com

Collected papers, interviews, video presentations, photos, and archival documents on the history of addiction treatment and recovery in America.

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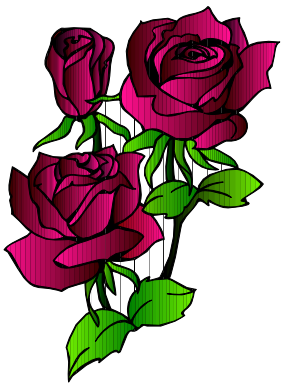
Gender Differences in Victimization Severity and Outcomes among Adolescents Treated for Substance Abuse

Chestnut Health Systems

Abstract

This article uses data from the Global Appraisal of Individual Needs (GAIN) on 214 adolescents entering substance abuse treatment. The goals of the article are to validate the General Victimization Index (GVI), examine its relationship to gender and co-occurring problems, and determine its relationship to outcomes. The GVI includes 15 items on lifetime traumatic events, traumagenic factors, and current worries of victimization. The items fall along a severity dimension (α =.88), and evidence was generated to support the construct validity of cutoff scores for interpretation. Girls were significantly more likely than boys to have experienced a variety of victimization incidents. When used as grouping variables, gender and severity of victimization significantly interacted with measures of intake status and were significant predictors of 3-month post-discharge treatment outcomes.



THE DELIVERY AND SUPERVISION OF OUTREACH SERVICES

Project SAFE

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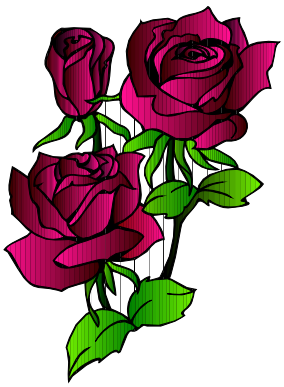

THE DELIVERY AND SUPERVISON OF OUTREACH SERVICES

Part I:

Voices of Hope:
An Orientation Manual
for Outreach Workers

You were always there for me,
the tender wind that carried me.
A light in the dark,
shining your love into my life.
You've been my inspiration,
through the lies you were the truth.
My world is a better place because of you.

You were my strength when I was weak,
You were my voice when I couldn't speak.
You were my eyes when I couldn't see,
you saw the best there was in me,
lifted me up when I couldn't reach.
You gave me faith, 'cause you believed.
I'm everything I am because you loved me.

From "Because You Loved Me"
Words and Music by Diane Warren
Performed by Celine Dion

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Warner Bros. Publications

Voices of Hope
An Orientation Manual for Outreach Workers

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Introduction

During the past ten years, Illinois has pioneered an innovative approach toward addressing the collision of maternal substance abuse and child maltreatment within the state. This initiative began with a Department of Health and Human Services demonstration grant that brought together the resources of the Illinois Department of Alcoholism and Substance Abuse (DASA) and the Illinois Department of Children and Family Services (DCFS), as well as local community resources, to provide substance abuse treatment to women with histories of abuse or neglect of their children. Between 1986 and 1996 this initiative, which came to be known as Project SAFE, spread to nineteen Illinois communities and treated more than 5,000 women and their families.

One of the most innovative aspects of Project SAFE is a style of outreach work that has eliminated many of the obstacles that have kept significant numbers of women from entering or successfully completing substance abuse treatment. The outreach services have been such an important part of the success of Project Safe that these services have been emulated in additional Illinois projects that involve collaborative efforts between DASA and DCFS. While our knowledge of how to deliver these outreach services has grown, it has existed primarily as a body of oral folklore passed from worker to worker. While this body of folklore is a rich one, much knowledge has been lost as outreach workers and their supervisors have changed positions within the field or left the field for new endeavors. This manual is an effort to stem this loss of knowledge.

The Outreach Worker Orientation Manual is designed to provide support to local agencies in their efforts to recruit, train, and supervise outreach workers who are working with addicted women and their families. The Manual has been designed for the widest possible utility. It may be read by a new outreach worker. It can serve as a framework of orientation used by an agency supervisor to acclimate a newly hired person to the role of outreach worker. It is also designed to be used as a training manual for regional or statewide orientation sessions for new outreach workers. A companion manual that also includes training tips and discussion guidelines for use with this manual has been developed for supervisors of outreach workers.

The information in this manual is drawn from the following sources: 1) a review of the professional and folk literature on the treatment of addicted women and their children, 2) information drawn from reports on evaluations of Project SAFE, and 3) interviews with Project SAFE outreach workers and outreach worker supervisors that were conducted in the Spring of 1996.

The addiction treatment field has struggled for more than a century to address the special needs of women and their children, and the greatest breakthroughs in service to these clients have occurred in the past twenty years. It is our hope that this manual will mark one more step in the progress toward the development of a gender-specific and circumstance-specific model of addiction treatment.

This manual is dedicated to the outreach workers and outreach worker supervisors who for the past ten years have helped sculpt a role that has made a profound difference in the lives of so many women and children in Illinois. Through your skill and your perseverance, you have touched the hearts of these women and children and improved the quality of life in our communities and in our state. We thank you.

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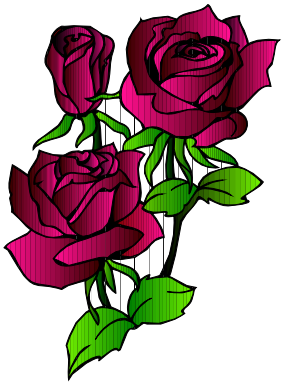

Section 1.0
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1.1 Addicted Women and Their Children

Learning Objectives

1. Identify at least three substance abuse trends that are having a significant effect on women and children.
2. Discuss the clinical profile of addicted women with histories of neglect or abuse of their children.
3. Discuss the implications of this clinical profile for the delivery of effective outreach services.

Drug Trends

Since 1980 there have been several dramatic changes in the nature of substance abuse in the United States.

The first area of change involves the drugs themselves. In the past fifteen years, we have seen a rise in the availability of drugs, a lowering of price that has brought drugs like cocaine into the reach of a broader range of people, and the appearance of more powerful forms of drugs and more efficient methods of taking them. Nowhere is this trend more evident that in the rise of cocaine addiction in the United States between 1982 and 1990. This trend had a profound impact on child welfare systems in the United States, primarily through a dramatic rise in the number of drug-exposed babies. Placements of children in New York increased fivefold between 1982 and 1990, while placements in California rose from 36,000 in 1982 to more than 75,000 in 1989. The number of drug-exposed babies reported to DCFS in Illinois rose from 297 in 1986 to 2,399 in 1990.

Cocaine continues to be the primary drug of choice of women entering treatment, but two new trends are also worth watching. First, a pattern of polydrug abuse (abuse of more than one drug) is beginning once again in the United States, marked by the increased use of cannabis, hallucinogens (including PCP), methamphetamine, and inhalants. The second trend involves an increase in the use of high-purity heroin, either by intranasal administration ("snorting") or by smoking. These increases in heroin use are occurring in two populations: 1) former cocaine users, and 2) a new generation of heroin users drawn from a cross-section of ethnic groups and social classes.

What might be some of the implications of these two trends for projects that intervene with substance-abusing mothers who neglect or abuse their children?

_____

_____

_____

A second area of change noted in the past two decades involves fundamental changes in the characteristics of people who abuse drugs. The first of these changes is that people begin abusing substances earlier in life. Many late adolescents and young adults entering treatment today report that they started abusing alcohol and/or other drugs at very early ages (for example, at 9-12 years old). The second change is the substantial rise in substance abuse by women in our culture.

What factors do you believe may have contributed to the rise in alcohol and other drug use among women and young people?

A third area of change involves the circumstances that tend to surround substance abuse in the United States. This change is marked by more and more intense drug-related criminal activity (related to cocaine), a rise in drug-related violence, and a rise in drug-related disease. Today we are much more likely to have women entering treatment who have been victimized by crime and violence and have participated in criminal and aggressive acts themselves. Substance abuse is also the fastest-growing risk factor related to the spread of HIV/AIDS in the United States. According to a 1996 report from the Centers for Disease Control, 28 percent of people diagnosed with AIDS report drug injection as their primary risk factor. Fifty percent of heterosexuals with AIDS are or have been partners of people who inject drugs. Seventy-two percent of children with AIDS were infected because of drug injection by one or both parents.

What are some of the implications of this group of trends for programs that serve women and children?

Clinical Profiles of Addicted Women: Service Delivery Implications

Substance Abuse Patterns

- Most women entering treatment are poly-addicted—addicted to more than one drug. Women are much more likely than men to be using more than one drug, and to be using both prescribed and illegal drugs at the same time.
- The beginning of substance abuse in women is often tied to a particular life event, like the beginning or end of a relationship, a death, hysterectomy or mastectomy, the beginning of menopause, etc. In many cases, such an event precipitates a move from substance use to substance abuse, or from the therapeutic use of prescription drugs to misuse of such substances.

- Alcoholism (and perhaps other addiction) progresses more rapidly in women.
- Addicted women report beginning use, increasing their use, and increased risk of relapse during premenstrual days.

Family and Developmental Histories

- More than 70 percent of women entering addiction treatment in Illinois report that one or both parents had a substance abuse problem.
- Self-reports of childhood sexual abuse by women in treatment range from 50 to 95 percent. Compared to non-substance-abusing women, substance-abusing women are more likely to have experienced sexual abuse beginning early in life, abuse over a long period of time, more than one sexual perpetrator, and more physical violence or threats of violence accompanying the sexual abuse. More substance-abusing women also report that they were not believed—or they were blamed—when they broke silence about the abuse.

What implications might this history pose for the following:

Mother-child relationships_____

_____

Adult intimate relationships_____

_____

Ability to trust people in helping relationships_____

_____

Tendency toward excessive behavior (risk-taking, crisis-orientation, etc.) _____

_____

Physical Health

- Women develop more complications from alcoholism after shorter periods of drinking and with less alcohol intake.
- Addicted women have a higher risk of obstetrical/gynecological problems, liver disease, cancer, and sexually transmitted diseases (STDs) than other women.
- Addicted women have a much higher risk of accidental death from synergistic drug interactions—where the *combination* of two or more drugs is much stronger than the added effects of the drugs themselves—than men have.

Because addicted women have such a high physical vulnerability, it is absolutely essential that these women be linked with health care resources for screening and treatment. Complaints of physical problems during early recovery should never be ignored.

Emotional Health

- Nearly half of the women entering Project SAFE in Illinois had been diagnosed with one or more psychiatric disorders other than alcoholism/addiction before they entered the Project. The most frequent of these diagnoses are depression, bipolar disorder (formerly called "manic-depressive disorder"), anxiety, and borderline personality. Addicted women entering treatment often report past thoughts of—and attempts at—suicide.

It appears that a significant percentage of women entering addiction treatment have both emotional problems and substance abuse problems. What are some potential implications of this for the delivery of outreach services?

_____

_____

_____

Intimate Relationships

- Addicted women are more likely to choose partners who have psychiatric problems that are similar or related to their own.
- Addicted women are more likely to choose partners who come from family backgrounds similar to their own.
- Addicted women present a general pattern of unstable intimate relationships, low levels of emotional satisfaction, and increased levels of conflict that can escalate into emotional/physical abuse.

Describe at least two implications of the above for the design of treatment programs and outreach services for addicted women with children.

1. _____

   _____

2. _____

   _____

Sexuality

According to the research of Stephanie Covington, alcohol and other drugs may play a dual role in addicted women's sexual problems. These drugs may temporarily relieve the symptoms of some of these problems, but they also tend to make the problems grow worse over time.

Obstacles to Treatment

- Women who have had a hard time entering and/or completing addiction treatment have

reported a number of obstacles, including inadequate child care resources, inadequate transportation, enabling (the inadvertant support of addiction through such mechanisms as the removal or withholding of addicion-related consequences by family members, friends, or co-workers), lack of financial resources, the stigma of being identified as addicted or needing help, restricted hours of agency services, and discomfort with male-oriented treatment philosophies and approaches.

- Women tend to enter treatment at later stages in the progression of addiction than men.

The primary reason for providing high-intensity outreach services is the presence of significant obstacles that keep women from entering and completing addiction treatment. Outreach services are designed to help women overcome these obstacles.

Substance Abuse and Parenting

Most studies of addicted mothers in treatment note a clear relationship between the beginning and worsening of substance abuse and the loss of their ability to fulfill their responsibilities as parents. Most clients in treatment report that incidents of neglect and overindulgence (in response to guilt) increased as their drug use progressed.
Although women who get clean and sober often show significantly less neglect of their children's needs, sobriety alone is often not enough to turn people into effective parents. Women often need interventions like parenting training and parenting coaching, so that they can learn and adopt effective parenting practices and "un-learn" the counterproductive parenting habits that may have existed before they began drinking and using addictively.

The link between substance abuse and child abuse is a complex one. The best predictor of a woman's risk to abuse her child after substance abuse treatment may have more to do with her own childhood history than with her substance abuse as an adult. Substance abuse may contribute to child abuse, rather than cause it. In assessing risk to the child, it's not enough to ask whether or not the mother is continuing to use drugs. This assessment should be based on a much broader field of information, including the woman's own developmental history.

What practical implications flow from these understandings? Record your observations below:

_____

_____

_____

Service History
Many addicted women and their families have long histories of failed interventions by health and human service agencies, as well as by other community institutions such as the schools, the courts, and the churches.

Some addicted women show chronic self-defeating styles that tend to sabotage efforts at involvement with helping professionals.

A barrier that prevents many addicted women from entering and/or completing treatment is a deeply rooted style of passivity, helplessness, hopelessness, and dependency (on drugs, people,

and institutions).

If a woman has a long history of negative involvement with helping institutions, describe what you should expect as this client opens her door to you for the first time.

_____

_____

How might you get through this resistance and develop an authentic (honest and effective) helping relationship?

_____

_____

Resilencies

We've come to recognize that many character traits and interaction styles that have traditionally been seen as pathological in addicted women are really signs of resilience—survival strategies that might have been necessary in childhood or in the drug culture, but don't work for adult women in sobriety. In light of the developmental histories of addicted women, how might each of the following traits been a strategy for physical and/or psychological survival?

A high distrust of others_____

_____

Manipulation _____

_____

Crisis orientation_____

_____

Lack of self-observation_____

_____

Lack of empathy_____

_____

High risk-taking behavior_____

_____

Make a list of the resiliencies of a client you are currently serving, by identifying the traits, abilities, and internal and external resources the client has that might support her recovery.

Resiliency List

1. _____

2. _____

3. _____

4. _____

5. _____

Reading Resources

Crack and Other Addictions: Old Realities and New Challenges for Child Welfare (1990). Washington, D.C.: Child Welfare League of America.

White, W.L. (1990). *Project SAFE Program Handbook.* Springfield, IL: Illinois Department of Children and Family Services.

Wilsnack, S. and Beckman, L. (1984). *Alcohol Problems in Women: Antecedents, Consequences and Interventions.* New York: Guilford Press.

Women and Alcohol: Health-related Issues (1986). NIAAA Research Monograph No. 16. Washington D.C.: U.S. Government Printing Office.

1.2 Multiple-Problem Clients and Families

Learning Objectives

1. Discuss at least two reasons why traditional service models have failed when applied to multiple-problem clients and their families.
2. Describe at least four elements of emerging multiple-problem client intervention models.
3. Describe the three primary functions of outreach workers in serving multiple-problem clients and their families.

Client Profile

We would like to introduce you to a family that has many problems and a long history of involvement with health and social service systems.

> *Maggie is a 23-year-old woman who has an eight-year history of substance abuse and a three-year history of cocaine addiction. She is an adult survivor of childhood sexual abuse. She has been hospitalized twice for suicide attempts and was diagnosed in the past with acute depression and borderline personality disorder. She has been involved in a long string of abusive relationships; and there have been domestic violence issues with her current paramour, who resides with Maggie and her children most of the time. Maggie has three children, the last two of whom were delivered drug-exposed. Two of Maggie's children have been returned to her after placement, and the third continues to live with her mother. Maggie's family has all but abandoned her, mostly because of her constant demands for money and her theft of property from family members. Maggie has been thrown out of her home twice in the past eighteen months, because money that should have gone toward the rent was spent on cocaine instead. Maggie has also had brushes with the law, mostly for shoplifting to get money for cocaine. Maggie's children show a number of developmental delays, and two of them are already showing emotional/behavioral problems. Maggie has no transportation to and from treatment and no current resources for child care. If we examined the involvement of Maggie and her children with service agencies over the past eight years, we would find a remarkably long history of brief interventions by a large number of agencies. Can you imagine how many dollars and how many staff hours from hospitals, clinics, schools, probation offices, and other social service and criminal justice agencies have been expended over these eight years? Maggie's story is typical of a growing number of multiple-problem clients and families who are caught up in the child welfare system and involved with a variety of allied agencies*

1. Would you guess that the quality of life and level of functioning of Maggie and her family is better today than it was eight years ago? ___Yes ___No

2. Please identify factors that may have contributed to the failure of these many service

interventions during the past eight years.

_____

_____

_____

_____

Failed Service Interventions

A growing understanding exists that, in a categorically segregated service system (agencies organized by individual problems), multiple-problem clients and families often fail. This failure is due to the following pattern of intervention:

Focus of the Intervention

Interventions focused on one problem at a time may fail because of the disruption produced by so-called "secondary" problems. There is a clear circular pattern and inter-connectedness among the problems in Maggie's life. This dooms to failure any intervention that focuses on a single problem without addressing the many other troubles that contribute to and spring from that problem. The focus of many failed interventions defined the problem as existing primarily inside the individual, rather than in the family system, kinship network, or broader social/economic environment.

Provider of the Intervention

Interventions delivered by one agency at a time—and often by one program and one discipline within an agency at a time—frequently fail because: 1) the assessment process is not comprehensive enough; 2) the client's problem is misdiagnosed (often because of the inadequate assessment); and 3) the intervention is too narrow (it addresses only one problem within a multi-problem client or kinship system).

Timing of the Intervention

Interventions with multiple-problem clients generally are crisis-oriented in nature.

Duration of the Intervention

Interventions with multiple-problem families often last only a short time, with service providers withdrawing or being removed from involvement before temporary changes can be instilled as permanent changes in lifestyle.

Environmental Obstacles

Many interventions with multiple-problem families ignore the real-life obstacles (for example, lack of child care and transportation, the problem of living in violent and drug-saturated neighborhoods) that can undermine effective service involvement.

Emerging Service Models

Project SAFE and The DCFS/DASA Initiative represent an effort to develop more effective models of serving multiple-problem clients and families. These new models tend to:

- Involve the pooled resources of **multiple agencies** at the federal, state, and local levels and the combined expertise of **multiple professional disciplines**. The model is **team focused**.
- Use an assessment process that emphasizes abilities and potential as well as deficits **(strength based rather than deficit based)**.
- Use aggressive programs of **outreach** and **case management** to engage the client and integrate the services from multiple agencies into a meaningful whole.
- Use a stage of **pretreatment,** with the primary goal of building a relationship with the client and instilling in her a sense of hope for the future.
- Attempt to treat the **whole family**.
- Address environmental obstacles to sustained service involvement, such as **child care** and **transportation**.
- Increase the **intensity and duration** of service involvement.
- Focus on a lifestyle-building process that involves and is supported by community-based resources.
- Help clients Identify and understand address clients' acts of **self-sabotage**, particularly passivity, learned helplessness, learned hopelessness, and dependency, and suggest more effective alternative styles of behavior.
- Rely on a service design that is highly **structured but flexible** to assist the client in working through the boundary testing that is typical during early stages of treatment.
- **Most important**, use a treatment design that is both **gender-specific** and **culturally appropriate**.

The Importance of Outreach

Outreach workers are the glue that makes our Illinois models work. Outreach workers are essential in: 1) engaging clients, 2) supporting clients through the continuing service-delivery process, and 3) linking clients to community resources that can help them sustain the progress they've made in treatment.

When DCFS workers and other community agency representatives were asked what role

outreach had played in the treatment of addicted women and their families, they were unreserved in their praise for the difference that outreach services had made:

> *Most of the clients I referred to Project SAFE wouldn't even have started treatment if it weren't for the persistence and encouragement of the outreach workers.*
>
> *Outreach services, and the case management activities integrated within those services, is our best attempt to piece together an integrated service plan out of a highly fragmented service delivery system. It's the outreach worker who keeps it all connected and jumps in to patch up glitches that occur in our systems of care.*
>
> *I think the biggest contribution of the outreach worker is in taking care of those very real problems that often kept women from starting or completing treatment—things like child care, transportation, and all the other daily problems that arise to keep women from getting to treatment.*

Here's what some clients had to say about what their outreach workers meant to them.

> *At first, I didn't want to come, and I didn't want to quit using, but Jan* [the outreach worker] *came knocking on my door every day, telling me I was going to make it to treatment no matter what. She would hunt me down and do whatever it took to get me involved. At first, she was a pain in my ass. But what I got out of it was a true friend—somebody I can trust. She's changed my whole life.*
>
> *It was her* [the outreach worker's] *persistence. She just kept coming around, you know, wearing me down. I got to thinking, "She ain't gonna leave me alone, so I might as well see if I can do it their way." And that's when I started to change.*
>
> *They* [the outreach workers] *can't do it for us. We got to do it ourselves. But they're there to stand by you and back you all the way.*
>
> *I've had a hard life and trusting ain't easy for me, but I can honestly say I got some trust now. I was hateful at first—I hated them all* [the agency staff]. *I thought they were all just doing their jobs, but she* [the outreach worker] *convinced me that it was more than a job—that she really cared about what happened to me and my children.*
>
> *She's* [the outreach worker] *been a cross between a friend and a mother—you know—loving but tough. She loves you, but she don't take no shit from no one.*
>
> *She* [the outreach worker] *was there to give me advice and be someone I could talk to openly about certain things. It was knowing that she would be there for me that helped get me through* [treatment].
>
> *She* [the outreach worker] *was always there when I needed to talk. And she'd always tell me to keep my head up, that things were going to work out.*
>
> *She* [the outreach worker] *helped me find a new way of life that I'm really excited about.*

I'll always appreciate the way she gave me hope.

We asked some clients in Project SAFE what advice they would give a new outreach worker. They all found a way to talk about the quality of patience.

> *Let them know that we are ladies that have gone through some hard times in our lives and to try to be patient with us and to be there when we need to talk.*
>
> *Be patient with us.*
>
> You got to put yourself in our place and be patient. It is very hard to get clean of drugs. Don't judge us; support us. Help those of us whose only goal was drugs get a positive goal.

Exercise

Having reviewed the material in this module, discuss how outreach services can contribute to the success of clients who have failed in programs that lacked outreach services. Jot down your ideas in the space provided below.

_____

_____

_____

_____

_____

_____

_____

_____

1.3 The Dependency Cluster

Learning Objectives

1. Identify the developmental stages of recovery most frequently experienced by women who successfully complete Project SAFE.
2. Discuss the implications of the "developmental model of recovery" for the role of outreach.

In the Appendix you'll find a paper entitled "A Developmental Model of Recovery." After reading the paper, complete the following true-and-false test. Discuss the answers with your supervisor or in your small discussion group.

True or False

___1. The term "toxic dependency" refers to the relationships that addicted women have with drugs, people, and helping institutions.

___2. The earliest developmental stage of recovery for addicted women involves issues of safety and trust.

___3. Women aren't ready for treatment until they hit bottom and experience a sincere desire to get sober.

___4. Many addicted women are, by themselves, constitutionally incapable of breaking their toxic relationships with drugs, people, and enabling institutions.

___5. The *primary* role of outreach workers in client engagement is to increase the client's experience of pain and consequences related to her drug use.

___6. Prospective clients who are experiencing low levels of hope and low levels of pain have a good prognosis for entering and successfully completing treatment.

___7. The most important tasks of the outreach worker are working through client resistance and eliminating obstacles that interfere with her ability to enter and complete treatment.

___8. The outreach worker's relationship with each client changes during the different developmental stages of recovery.

___9. What is appropriate and helpful to do for a woman in the early stages of treatment may be inappropriate and harmful in the late stages of treatment.

__10. During the stage of sisterhood, when clients bond closely with one another, this peer

influence can work either to support or to sabotage recovery.

__11. The primary role of the outreach worker in the late stages of treatment is helping the client reconstruct a lifestyle and a sobriety-based support structure in the community.

__12. Women in treatment should be strongly discouraged from dealing with issues of childhood victimization, because exploring such issues is a late-stage recovery task.

What are the most important implications of this paper for the role of an outreach worker serving addicted women and their children? Note your observations below.

_____

_____

_____

_____

_____

1.4 Learned Helplessness: Implications for Outreach

Learning Objectives

1. Discuss the concepts of learned helplessness and learned helplessness depression, as those concepts relate to Project SAFE clients.
2. Identify elements of clients' life histories that have led to the development of learned helplessness.
3. Identify ways in which this condition complicates treatment and outreach efforts.
4. Identify ways in which outreach workers can help women overcome learned helplessness and be empowered to recover.

A New Name for an Old Condition

You've probably seen it more times than you'd like to remember: A woman lives for years in conditions that cause her pain, deprive her of what she needs, and/or threaten her life. Even when she gets an opportunity to escape the nightmare, she lets the opportunity slip past her. She always has reasons for staying, but those reasons don't always make sense. What's really holding her back?

The concept of Learned Helplessness helps us understand this kind of decision pattern. When people—particularly children—are taught over and over again by their life experiences that they have no power to protect themselves, they tend to give up. Even if their circumstances change later in life, they're often unable to change their decision patterns. It's as if their self-protective powers were being held down by some unseen force. A study conducted in the early 1970s shows how this condition works.

In that study, researchers put a group of dogs into cages. Then the researchers gave a mild electric shock to the dogs through the metal floors of the cages.

The dogs all started barking and trying to escape. But after they'd been shocked repeatedly over a long period of time, they stopped barking and trying to escape. Instead, whenever they were given an electric shock, they lay down on the floors of the cages and cried. This continued even after the doors of the cages were opened and the researchers tried to coax or pull them out. When electric shocks were administered, the dogs still lay down and cried.Compare that pattern to the behavior of a client who is unable to leave her abusive paramour, even after you've shown her a way out. And what about the woman who can't seem to look for a job or a place to live, even though she's competent and she's been clean for a while? Your client might have a history of being very willful about alcohol and other drugs. But when she needs to protect herself or build a healthy life, it's as if she has no will to survive. This is learned helplessness depression.

1. Think of the women you've served as an outreach worker. What percentage would you say suffer from learned helplessness depression?

_____

_____

2. What are some of the signs of this condition that you hear in your clients' words and see in their behavior?

_____

_____

_____

_____

How Learned Helplessness Develops

Think of a small child with an adult whom the child loves and depends on for food, clothing, shelter, attention, play, etc. The adult is the child's source of authority, the one who decides what's right or wrong. If the adult says or does something that is abusive, how would the child know that the adult is breaking the rules? After all, the adult is the one who makes the rules. Many things that adults make children do are painful—going to the dentist, for example. How is the child to know that the abuse is any different?

As the abuse continues, the child learns that there's nothing she can do to stop the abuse or escape the situation. Often she's been told by the abuser that, if she tells anyone or does anything to try to escape, the abuse will get worse. And if she does try any of those actions, in most cases she isn't believed and the abuse does get worse. She gives up on the possibility of escaping the abuse, and retreats inside herself for comfort. She learns to dissociate—to pretend that she doesn't feel those intolerable feelings, and that her painful and humiliating experiences are happening to someone else.

The only way the child can tolerate the abuse is to believe that she has somehow caused it, by doing or being something bad. If she caused it, she must have some kind of power, even if it's just the power to be a bad person. So she learns to believe she's responsible and to blame herself, and the people around her do nothing to challenge that belief. In fact, they often tell her that she deserves to be punished, and that the punishment is a sign of their love. Toxic shame and guilt take hold in every area of her life. The more she's abused, the more guilty she feels.

What has the child learned from these experiences? What are the messages she's heard and believed? You have no rights. You have no say over what happens to you. Your power to make

decisions about your life has been taken over by someone else—it's not your power any more. You **have** no power. Nothing you can do will make it any better for you, and anything you try is likely to make it worse. No one can help you. No one will even believe you. You have no hope. It's your fault, too. It's because you're basically bad and worthless. Anyone who loves you will hurt you, because you deserve to be punished.

In adult life, she'll be attracted to people who mistreat her, because they seem familiar and because she doesn't believe she deserves any better treatment. She'll be afraid of, or angry with, people who try to help her. If she abuses her own children, she'll believe at the time that she's doing it because she loves them. But if she has abused or neglected her children, her shame and guilt will be so intense that she'll seek out people and experiences that will punish her for her actions. The abuse or neglect of her own children can become a way of keeping the guilt alive, making sure she never serves her "sentence" in full, no matter how much she suffers.

1. Think of a client you know well who suffers from learned helplessness. What was her life like when she was a child?

   _____

   _____

2. What does this woman say or do that might make you think she believes she has no rights, no power, and no hope?

   _____

   _____

3. What does she say or do that might make you think she believes she can't do anything right?

   _____

   _____

4. What does she say that might make you think she blames herself for all the painful things that have happened?

   _____

   _____

5. How does she punish herself—or let others punish her—for the shame and guilt that she believes is hers?

   _____

_____

Challenges for the Outreach Worker

When a client's entire belief system is set against her success—at anything—it's hard to help her believe in herself. Her learned helplessness has paralyzed the part of her that's capable of believing in her potential. It doesn't help simply to say, "Go on, you can get an apartment! You can find a job! Just do it!" It would be like telling someone in a wheelchair to get up and run across the room. The more you expect of her before she's ready, the more shame and guilt she feels at not being able to meet your expectations, and the more she's convinced of her own worthlessness and uselessness.

1. Think of a client who doesn't believe she can help or protect herself. What words might you use to let her know that you really do understand how she feels?

   _____

   _____

   _____

   _____

2. What words or actions might you use to let her know you believe in her?

   _____

   _____

   _____

   _____

3. What parts of her personality or her behavior can you show her as evidence that she's capable and resourceful?

   _____

   _____

   _____

   _____

Healing Learned Helplessness

Because learned helplessness is so deeply rooted, it takes a long time and quite a bit of care just to begin the healing process. Creating a safe atmosphere for healing is the first and most important part of that care. That's why your honesty, respect, fairness, consistency, and reliability are so important. Project SAFE may be the first safe place your clients have ever found.

Often clients have dissociated or blocked themselves off from their painful feelings, including anger and rage at the people who have abused them. When they were children, the numbness protected them from the worst part of their pain. Now that they're adults, the numbness locks the pain in so it can't be healed. You may have found yourself feeling anger on behalf of a client who feels little or no anger at the people who have abused her. It's as if you're carrying her anger for her, keeping it safe until it's safe for her to feel it herself.

When clients start to feel their anger and other unpleasant feelings, it's a sign that they're starting to get well. One mistake that traditional treatment programs make is to punish women for getting angry: "Control your temper of you're out of here!" That just reinforces the client's old pattern of burying her feelings. One of the reasons Project SAFE is so empowering is that women are allowed to feel their anger and encouraged to express it in appropriate ways.

When a client's anger does begin to surface, it may come up in the form of rage. That rage might not be directed at the people who are responsible for it. Instead, it might be directed at other clients, at people who remind her of the ones who abused her in her childhood, or at you. You can begin to help by understanding her anger for what it is: something natural and normal that she has to go through in order to get well.

Through your words and your example, you can teach her that it's okay to feel angry. It's possible to deal with the anger in constructive ways—even channel the energy of anger into actions that she wants or needs to take for her own well-being. You can also help her understand that she won't be helping herself—and she might be making her life a lot worse—if she reacts to the anger by hurting herself or others.

It's equally important to respect those times when she has to "shut down" for her own emotional survival. When she's feeling her negative feelings, you can help her process those feelings. But when she's out of touch with her feelings, that means it's not safe for her to feel them. Your best reaction is simply to "meet her where she is"—to work with whatever thoughts and feelings she's willing and able to give you at the time. That way she'll know it's safe to open up when she needs to open up, and it's safe to close down when that's what she needs.

As an outreach worker, you're in a unique position to help the client move from learned helplessness to empowerment. In the beginning, you may have to do things for her, as if she were a child. As time passes, you move into the role of doing things **with** her, giving her a

chance to try new things and learn new skills. Then you gradually remove your own efforts and gently but firmly guide her as she starts to take responsibility for her own life. You let her stretch her wings, but you stay available in case she needs to rest—or fall on her face.

The messages you're giving her are the exact opposites of the ones she learned as a child: You have rights. You have some say over what happens to you. You have the power to make decisions about your life. You can do things to make your life better. Some people can and will help you. Some people will believe you, and believe **in** you. You have hope. Like everyone else, you've made mistakes, but the abuse you've suffered at the hands of others is not your fault. You didn't cause it. People who love you don't abuse you. You don't deserve to suffer. You deserve to be happy and free.

1. What is it about you that helps women feel safe around you?

_____

_____

_____

_____

2. What qualities in yourself would you like to improve so that your clients' safety will be improved?

_____

_____

_____

_____

3. How do you feel when clients get angry? What do you say? What do you do?

_____

_____

_____

_____

4. What are some things you can do to encourage women to deal with anger in constructive ways?

_____

_____

_____

_____

5. How do you feel when clients seem emotionally numb? What do you say? What do you do?

_____

_____

_____

_____

6. Re-read the paragraph about empowerment (the second-to-last paragraph, above). What's the hardest thing about that process for you?

_____

_____

_____

_____

7. There's a module on "Empowerment" later in this manual. Where else could you go for help or guidance in becoming more comfortable with the empowerment process?

_____

_____

8. What might you tell yourself that would make the empowerment process easier for you?

_____

_____

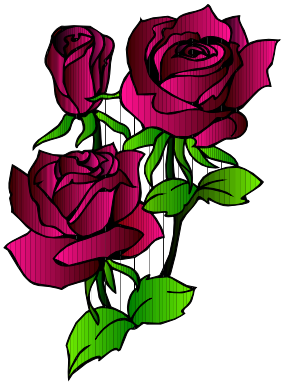
9. Of the healing "messages" that you give women through your work in Project SAFE, which ones seem most powerful in helping them recover?

_____

_____

_____

_____



Section 2.0
Becoming an Outreach Worker

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2.1 What Does an Outreach Worker Do?

Learning Objectives

1. Discuss some of the roles that many outreach workers play in their clients' lives, and identify the roles that you do or don't play in your position as an outreach worker.
2. Discuss some of the ways in which those roles might sometimes conflict with one another, even though you're doing your best to help your clients.
3. Discuss the three roles (or tasks) that are the most difficult for you because of who you are and what you've been through (or haven't been through) in your own life—or because of your work situation—and some possible ways of overcoming those difficulties.
4. Discuss the three roles in which you feel most effective and successful in helping your clients, and why these roles come naturally to you.

The Natural Birth of the Outreach Worker's Role

More than any other position in Project Safe, the outreach worker's role was created by the outreach workers themselves, based on client needs. When the project began, the outreach workers were not assigned to the intense treatment attraction and encouragement role that they play today. Their duties were supposed to begin when women entered treatment.

But the early outreach workers had little or nothing to do while they waited for the first clients to decide to accept treatment. So they started calling potential clients, giving them information and encouragement, and slowly and patiently proving that they could be trusted. Now most people involved in the project will tell you that the outreach workers' efforts are often the biggest reason women are able to enter and stay in treatment.

"You must be there when they hit bottom," said one outreach worker. "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 bottom alone, she reaches for the drug and addiction continues. When she hits bottom and *I'm* there (representing hope), change is possible."

The Many Roles of an Outreach Worker

"I sometimes feel like what a seeing eye dog may feel like," said another outreach worker. "Sometimes they're just blind and that's all they can do, hold on to the back of your shirt and walk wherever you take them." Of course, the outreach worker's job is much more complicated than simply turning left here, right there, and stopping at red lights.

Here are some of the roles that Project SAFE outreach workers play in women's lives, and the things they sometimes need to do in those roles. These are taken from a series of interviews with outreach workers. Not every outreach worker plays every one of these roles or does every one of these things. Some host agencies have policies against having outreach workers perform some of these tasks. Some agencies have other staff performing some of these tasks instead of outreach workers.

As you read through this list: 1) Cross out any roles or tasks you don't do because your agency has a policy against them, because other people are assigned to them, or for any other reason; and 2) circle any roles or tasks that take up much of your time or energy. When you've finished reading, write in any of your roles or tasks that are missing from the list.

- **Irresistible Force:** When she's still resisting your visits or your efforts to get her into treatment, going back time and time again, letting her know that you're there for her and you're not going to give up on her, and wearing down her resistance with your patience and your belief in her.
- **Friend:** Listening, listening, listening; building trust by being honest, keeping your word, and sticking with the client; seeing her as an equal; not judging or looking down on her; not making excuses for her; understanding how hard it is for her; being there when she's scared, sad, and angry; laughing with her.
- **Cheerleader:** Encouraging her to keep trying even though she believes she can't do it; letting her be exactly who she is, but showing and telling her that you believe in her ability to be who she wants to be; celebrating her entry into treatment and her graduation from treatment; marking all the times she's done things right.
- **Mother/Nurturer:** Loving her even when you don't like her; giving her the kind of consistent caring that most clients' mothers weren't able to give them; showing her how proud you are of even her smallest successes.
- **Crisis Counselor:** Being there for her when she's hitting bottom, grieving a loss, going through a crisis, or losing control; being calm when she's falling apart; thinking of consequences and possible solutions when she can't; teaching her by example how to think of consequences and choose solutions; not taking it personally or showing your frustration when she yells at you, blames you for her problems, refuses to talk to you, refuses to let you in, or tries to manipulate you.
- **Role Model:** Telling her about some of the ways you've overcome problems in your own life; showing by your own example how to be a responsible, successful, clean, healthy, honest, positive, growing, learning, loving, caring, respectful, self-respectful, dignified human being.
- **Diplomat:** Helping family members learn how to respond appropriately and productively to her addiction and her behavior; knowing what to say and what not to say about the client to her family; helping the client understand the DCFS case worker and the case worker understand the client; maintaining smooth relations with DCFS, the court system, and other agencies; keeping the women from fighting with one another in transport, but instead teaching them to take their conflicts into group for processing.
- **Advocate:** Looking out for her rights and those of her children, and speaking up when

her rights or her children's rights are being violated.

- **Monitor:** Looking for and pointing out safety problems in the home, and suggesting ways of solving those problems; taking urine drops; noticing signs of domestic violence and linking the client to shelters and people who can help; noticing and reporting to DCFS any signs of child abuse or neglect.
- **Chauffeur:** Picking up all of your clients and their children, taking the children to child care and the women to group; taking individual clients to accomplish important survival tasks that they can't get to otherwise; keeping everyone in the vehicle safe even though some of them are emotionally, verbally, and physically out of control; keeping the vehicle in working order and getting things fixed before they break down.
- **Home Consultant:** Helping the client learn—or find resources to learn—how to clean her house, make a grocery list, buy groceries, get access to organizations that give away food, cook, care for her children's hygiene, care for her own hygiene, and decorate her home with little or no money.
- **Housing, Transportation, and Educational Consultant:** Helping her find appropriate housing if she's homeless or living in an unsafe place; helping her learn how to use the public transit system; helping her get bus tokens from service agencies; helping her find the right schools for her children and get her children's paperwork processed; encouraging her to go back to school when she's ready, and helping her find ways of doing that.
- **Medical Consultant:** Noticing signs of sickness or injury in the client and her children; telling her about "common-sense" home remedies when these are appropriate; helping her find and choose appropriate medical care; taking her and her children to the doctor or clinic for checkups and medical care, when that's needed.
- **Recovery Facilitator:** Helping her understand her addiction, the importance of recovery, and the dangers of continuing to use; helping her understand what relapse is and why she doesn't have to hide from you or beat herself up if she's relapsed; introducing her to the self-help groups that address her needs and helping her understand what to expect in those groups and how to get the most out of them; giving her meeting schedules and helping her find safe transportation to them; taking her to meetings and introducing her to women with substantial clean time who might be good sponsors or role models.
- **Financial Consultant:** Helping her learn to understand the consequences of not paying bills, pay her bills on time, keep track of her money, save for emergencies, and apply to the appropriate agencies for financial help.
- **Record-Keeper:** Keeping a daily log of all activities with each woman; filling out billing forms on a timely basis instead of letting them all pile up at the end of the month; making to-do lists and sharing them with your supervisor; writing notes about anything you need from other staff; filling out all other forms your agency asks you to fill out.
- **Team-Player:** Meeting with your supervisor when it's required or when you have a situation you need to talk about; attending weekly staffings with your supervisor, case managers, counselors, other outreach workers, and DCFS case workers; sharing information about your clients with other staff in order to keep staff members from being "played" against one another; showing clients a united staff who won't be played against one another.

- **Teacher:** Leading group information sessions on personal care, child care, family issues, health and wellness, or stress management; linking clients with people who can help them improve their reading skills, including other clients who can act as tutors.
- _____
  _____
  _____
  _____
- _____
  _____
  _____
  _____
- _____
  _____
  _____
  _____

Take a minute to look at all the roles and actions that are left on that list, even if you've crossed some off. It will probably be a very long list of things you already do or may be called on to do. These are all important roles and tasks. In some cases they make all the difference in a client's ability to get into treatment, make it through treatment, stay clean, or be an effective mother for her children. If you ever have any doubts about the importance of your role as an outreach worker, remember this list.

Role Conflicts

Read through those roles again, and the things that outreach workers do as part of those roles. As you read, pay attention to your "gut" feelings. If you're already working as an outreach worker, think of experiences you've had with each of these roles, and with combinations of roles. Have you ever experienced any conflicts between two or more roles that are part of your responsibilities as an outreach worker? If you're just starting your job, use your imagination to think of ways in which some of these roles might sometimes conflict with one another. Take this scenario as an example:

Denise is fairly new to the project and has little or no self-esteem. You've been trying to help her with that, and she's just starting to be able to trust you. She's is receiving interim services while on the waiting list to get into group, and you visit her once a week, or more often when it's necessary. You recently helped her straighten out a misunderstanding with her family and her DCFS case worker so that she could have unsupervised visits with her children, as was set forth in her court decree.

Today you went with Denise on her visit with her children, and you saw her neglecting her children's basic needs, including their safety needs. You suggested and modeled other ways of interacting with the children, and made a commitment to help her improve her parenting skills. She seemed ashamed of her skill level, said that she was willing to learn, but didn't seem to understand what you were saying. You left the situation with a strong gut feeling that her children wouldn't be safe left alone with her on those visits.

1. What roles have you been playing in Denise's life?

_____

_____

_____

2. Which roles, if any, might seem to be in conflict with one another; and what are some of the reasons for that conflict?

_____

_____

_____

_____

_____

_____

3. How do you feel when you're expected to play these or other conflicting roles?

_____

_____

4. How do you think Denise feels if you're trying to play conflicting roles?

_____

_____

5. What, if anything, can you do to lower the level of conflict between the roles you need to play, become more comfortable with the conflict that exists, and/or get help in deciding how to handle the situation?

6. How might you handle the situation?

Most Difficult Roles

Of all the roles described on the list, name the three that are most difficult for you to play, and tell what it is about you, your experience, or your situation that makes those roles difficult.

First Difficult Role:

Second Difficult Role:

Third Difficult Role:

For each of the difficult roles, what help can you get in making it easier to learn to play that role, or—if that doesn't work—in finding a way to share the burden of that role so you're not facing it alone?

Help for the First Role:

Help for the Second Role:

_____

Help for the Third Role:

_____

_____

_____

Most Successful Roles

Of all the roles on the list, name the three that you believe you play most successfully, with the strongest positive effects on your clients' lives and recovery. For each of the three roles, tell what it is about you, your experience, or your situation that makes you most successful in that role. If you're new to outreach, choose the roles that you believe will come most easily to you.

First Successful Role:

_____

_____

_____

Second Successful Role:

_____

_____

_____

Third Successful Role:

_____

_____

_____

Congratulate yourself on the incredible job you're doing juggling all these roles and tasks! If you're just starting out, you can be proud of your commitment and courage in taking this job. Please don't be intimidated by the wide variety of roles and duties. There are supervisors and other outreach workers—at your site and other sites—who can help you through the challenges of the early days.

2.2 Outreach: What Does it Take?

Learning Objectives

1. Understand and discuss, from the client's viewpoint, the most important qualities for an outreach worker to have.
2. Honestly assess your current level of progress on the ideal qualities for an outreach worker.
3. Identify people in your life who are strong in the qualities you most need to work on, so that they can serve as mentors for you.
4. Discuss some of the ways in which experience of addiction and recovery can increase or decrease an outreach worker's effectiveness, and steps that outreach workers can take to make sure their own history doesn't complicate or endanger the outreach process.

What Does it Take?

If you've just read the list of outreach worker roles in the last module, you might feel like effective outreach requires a saint, a perfect person, or a super hero. Well, it doesn't. There are plenty of excellent outreach workers who sometimes make mistakes, doubt themselves, and fall short of their own and their clients' expectations. You'll be looking a little more closely at realistic expectations a little later in this manual. In the meantime, look at the ideal—not as something to feel "less than," but as a light to guide you.

A Client's-Eye View

For a moment, please forget who you are, where you are, and what your life is like right now. Put your mind and your emotions in the place of those of a client. If you're a former client—or someone else who's had quite a bit of pain and problems in her life—that experience will help you identify. If not, you can call on your imagination, or on your empathy for your clients.

> *You're 20 years old. You grew up in a housing project, in an apartment with your alcoholic mother, your grandmother, and your three uncles. Your mother sometimes beat you when she was in blackouts. You were first sexually abused when you were eight, by one of your uncles, and the abuse continued until you were 13. At that point you were pregnant, and you admitted to your mother who the baby's father was. Neither she nor your grandmother believed you, and they kicked you out of the apartment. You never went back to school after that. You blamed yourself for the abuse, and for having been kicked out.*
>
> *You've been drinking since you were nine, and smoking crack cocaine since you were 16. You had your first baby at age 14. You have three children, all by different fathers, placed in separate homes by DCFS. You love your children and you miss them, but you*

wouldn't have the first idea how to take care of them. Sometimes you live in shelters, sometimes with boyfriends, sometimes in abandoned buildings, and sometimes on the street.

You don't remember ever feeling good about yourself or ever trusting anyone. Anyone who was ever nice to you turned out to have some kind of angle, something they wanted from you. You came to expect that, very early. You've always jumped between doing what you thought people wanted you to do and lashing out in uncontrollable anger. You're convinced that you're crazy, and sometimes you think it's because you're basically evil and worthless. You can't picture anyone really loving you.

You've been in contact with social service agencies since your first pregnancy, and you've had many different case workers and dealt with personnel from a number of agencies. Most of them seemed to be judging you and seeing you as lower than them, even if they didn't say anything about it. Part of you agreed with them. There were a couple who were nice, but they were pretty stupid and easy to fool. They didn't last long. Either they quit their jobs or their programs stopped being funded, or you never knew what happened to them—they just went away.

You've tried to get clean by yourself a few times, but you've relapsed pretty quickly and it's always made you feel even worse about yourself. The idea of treatment and recovery groups terrifies you. You can picture everyone judging you and putting you down and looking at you like you're a piece of dirt. Now a woman has called you at the shelter, saying she's an outreach worker from Project SAFE, a treatment program for women. She says DCFS has made a referral on you, and she's coming in this afternoon to talk to you. You said okay, but the idea has brought back quite a bit of fear and anger about all the people who have said they were going to help, but really just made you feel worse about yourself, then abandoned you.

What qualities would you want and need this outreach worker to have if she's going to be able to help you, and how would you want her to treat you?

_____

_____

_____

_____

_____

_____

_____

Now take a minute to come back to yourself. You're not that client; you're an outreach worker with skills and talents and resources to help her do her work. Think about your life as it is today, your friends and co-workers, your family, your interests, your hopes, and your dreams.

Now look at the description you wrote of the outreach worker that the client would like to meet. Is it a description of you? Which of those ideal qualities do you already have, and which of those behaviors do you already show?

_____

_____

What are some of those ideal qualities and behaviors that you'd like to work on and improve in your own work?

_____

_____

What people, materials, activities, and other resources do you know that could help you work on developing those qualities and behaviors?

_____

_____

_____

What Some Outreach Workers Say

Even long-time veterans of the outreach role say that their job takes quite a bit of skill and flexibility. "You have to try to put them [the clients] at ease from the beginning, not go in and be boisterous and demanding," said one outreach worker. "Use some compassion. Try to assess the situation. Outreach is a versatile type of job. You have to change your moves to fit the particular person."

"When you go into their environment and you can't look around because things may be out of place, or things may be crawling, you can't focus on that," said another. "You just have to focus on the client, because they know if you're uncomfortable. They will sense that right away."

"We have to stay focused—like a guided missile. We have to sort through all the chaos of this woman's life and keep the focus on treatment and recovery."

The process of drawing a woman into treatment is often little more than a process of wearing down her resistance. That's where the persistence comes in. "They get to the point where they want to get you off their back," said one outreach worker. "They just surrender."

The intensity of the outreach worker's giving and nurturing requires that the worker also be receiving nurturing in other areas of life. "In order to be able to give away something, you have to have something to give away. If you're not being spiritually fed, it's hard." (See the module on "Stress, Strain, and Strategies of Self-Care.")

Self-Assessment of Progress

The following is a list of ideal qualities of an outreach worker that came out of a series of interviews with outreach workers and clients. In the middle column, rate your present level of progress on each quality from 0 to 10. Zero means "I don't have that quality at all yet," and 10 means "That quality comes naturally to me, and I show it consistently."

Writing a zero doesn't mean you'll never get that quality; it just means you haven't had the right conditions to develop it. Writing a 10 doesn't mean you're bragging; it just means you were born or raised with that quality or you've worked very hard on it.

In the line in the right-hand column, write the name of someone in your life who is strong in that quality. It might be a co-worker, a friend, a family member, a teacher, or someone else you can contact. You can use the same name for more than one quality, or for as many as you like. There are a few blank lines at the end of the list, so you can add qualities that are missing from the list.

Quality	**Present Level of Progress (0-10)**	**Person Who Has That Quality**
Knowledge of addiction and recovery	_____	_____
Knowledge of treatment	_____	_____
Freedom from drugs and alcohol	_____	_____
Tolerance for relapse	_____	_____
Knowledge of dual disorders	_____	_____
Knowledge of drugs and their effects	_____	_____
Resolution of major childhood issues	_____	_____
Feeling of equality with the client	_____	_____
Acceptance of people as they are	_____	_____
Sense of humor	_____	_____
Honesty with gentleness and care	_____	_____
Unconditional love	_____	_____
Street smarts	_____	_____

Quality	**Present Level of Progress (0-10)**	**Person Who Has That Quality**

Trust, but not blind trust	_____	_____
Knowledge of yourself and your true needs	_____	_____
Ability to cope with others' anger	_____	_____
Ability not to take things personally	_____	_____
Openness to many ways of doing things	_____	_____
Openness to many different personalities	_____	_____
Sense of spiritual connection and trust	_____	_____
Tolerance for dirty or messy environments	_____	_____
Enthusiasm	_____	_____
Easy-going disposition	_____	_____
Persistence	_____	_____
Patience	_____	_____
Ability to forgive yourself	_____	_____
Ability to forgive others	_____	_____
Ability to keep information confidential	_____	_____
Ability to see the simple in the complicated	_____	_____
Compassion and empathy	_____	_____
Strong will and determination	_____	_____
Desire to be with people	_____	_____
Good listening skills	_____	_____
Good communication skills	_____	_____
Ability to simply be present	_____	_____
Respect	_____	_____
Awareness of "gut" feelings and instincts	_____	_____
Flexibility	_____	_____
Good problem-solving skills	_____	_____
Ability not to show fear	_____	_____
Ability not to show anger	_____	_____

Quality	**Present Level of Progress (0-10)**	**Person Who Has That Quality**

Common sense		
Ability to “say it straight”		
Ability to resist manipulation		
Non-threatening personality		
Ability to focus on the client		
Diplomacy		
Willingness to see to your own needs		
Responsibility		
Dependability		
Ability to treat different people differently		
Integrity		
Ability to see through lies		
Loyalty tempered by realism		
Fairness		
Tough love		
Ability to set limits and protect boundaries		
Vision of the person behind the illness		
Ability to re-parent the client		
Ability to juggle many roles		
Ability to confront respectfully		
Bold faith		
Understanding		
Deep commitment		
Respect for the client’s turf		
Respect for the client’s culture		
Gratitude		
Instinct for when to talk or be silent		
Sense of identification with the client		

Quality	**Present Level of Progress (0-10)**	**Person Who Has That Quality**

Ability to be yourself with the client	_____	_____
Desire to be part of a team	_____	_____
Willingness to learn	_____	_____
Willingness to do paperwork on time	_____	_____
Ability to take criticism and improve	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Now look at the qualities in which you rated your progress at 5 or below. Make a list of the people whose names you've written next to those qualities.

_____	_____
_____	_____
_____	_____
_____	_____

These people would make good mentors for you—examples and sources of encouragement in developing the qualities you need for your work. You can make a commitment to spend more time with these people, and even ask them how they developed these qualities.

Experience of Addiction and Recovery

Many outreach workers are recovering from chemical dependency. Others have no addiction history of their own, but they've been close to someone else's active addiction—perhaps that of a parent, a close friend, or a significant other. They, too, may be going through a recovery process for the effects of living with another's addiction.

This first-hand experience of addiction and recovery can add to an outreach worker's effectiveness. In some cases, though, it can also complicate the outreach process and pose some dangers to the outreach worker and to the client.

What are some ways in which being in recovery might make an outreach worker more effective in reaching and helping women?

_____

_____

_____

_____

What are some ways in which the outreach worker's addiction and recovery history might complicate the outreach process?

_____

_____

_____

_____

What are some possible dangers to the outreach worker?

_____

_____

What are some possible dangers to the client?

_____

_____

Most Project Safe sites set a minimum sobriety time (between one and four years) for outreach workers who are in recovery. This is to give people time to get stable in their recovery, work through their early recovery issues, and get as far as possible in facing and managing the effects of the painful circumstances in their past lives. It also makes it less dangerous for them to go into environments where alcohol and drugs may be right there in plain sight and scent, triggering cravings.

If people don't have enough recovery time and healing behind them, they sometimes project their "stuff" onto others who are trying to recover. They can start believing that others should recover exactly as they did, and interpreting others' problems as if they were exactly like their own. This makes it hard for clients whose needs and personalities are different from those of their outreach workers.

People who haven't had enough recovery time to heal their childhood wounds often find the pain and chaos of clients' lives a trigger for their own intense pain and fear. This can happen no matter how good their recovery program may be. Sometimes it takes many years in recovery before it's safe for these issues to surface and be healed.

What kind of "stuff" can an outreach worker who has a history of addiction and recovery—or unresolved issues from living with another person's addiction—bring to work that can interfere with effective service relationships with clients?

_____

_____

_____

_____

What are some steps that outreach workers in recovery can take to make sure their history is only

an asset to the outreach process, and not an obstacle or a danger?

_____

_____

_____

_____

_____

2.3 Early Fears

Objectives

1. Identify and separate the major types of fears that are common to new outreach workers (safety-related fears, fear of the client, fear for the client, and fear of failure).
2. Accept a respectful attitude toward safety-related fears and refer to the module on Safety Tips.
3. Discuss some of the ways in which the client's emotional outbursts or "shutting down" can be intimidating, and ways of bypassing and overcoming that intimidation.
4. Discuss some of the legitimate fears for the client's or her children's safety and well-being that outreach workers face, and ways of living with those fears.
5. Discuss the fear of personal failure as an outreach worker, and ways of functioning in spite of that fear and eventually overcoming it.

Divide and Conquer

Most jobs hold some fear in the early days. It makes sense that a job like outreach, with its dangers and its unknown elements, would sometimes be particularly scary to new workers. This module is about understanding and dealing with those early fears.

One of the reasons fear can have such a powerful hold on us is that many unrelated fears often cluster together and feel like one huge, insurmountable fear. We feel overwhelmed by this fear because it's so hard to understand. It feels like one kind of fear one minute, and another kind the next. Pretty soon it feels as if we're afraid of everything.

So the first step in coping with fear is to sort it out, to separate and identify all the different fears that are at work. Then we can decide how to cope with each fear based on what it is and where it comes from. This module addresses separately the four types of early fears that outreach workers have identified in their interviews:

- safety-related fears
- fear of the client's behavior and emotional force
- fear for the client's or her children's well-being
- fear of failure as an outreach worker.

Safety-Related Fears

These are the most common fears—and very important ones. Many clients have violent tempers and live in violent situations, within violent neighborhoods. Many outreach workers describe the fear that goes along with a trip into public housing projects, or the fear of "Going up to the door, not knowing what's behind the door."

You need to read and work the module called "Safety Tips for Outreach Workers." Raising your level of safety will lower your level of fear, along with your level of danger. But the most important way to respond to safety-related fears is to pay attention to them. Respect them. They might save your life.

If your gut instinct is telling you a situation isn't safe, you need to get out of that situation. In the words of one supervisor, "I'd strongly encourage the outreach workers to trust their instincts. If you're feeling unsafe, leave. We'll go back later." You need to talk to your supervisor about your fears, talk to other outreach workers, study all the safety tips, and obey your instinct for self-preservation.

How do you know when you're feeling a safety-related fear? What are some of the thoughts you have at those times?

_____
_____

What are some of the physical feelings you get when you're afraid?

_____
_____

What do you usually have an urge to do when you're afraid?

_____
_____

What do you actually tend to do?

_____

_____

Some people have a tendency to "freeze up" when they're in physical danger, so they can't move or protect themselves. Others tend to ignore their fears and take dangerous risks. If you tend to do either of those things, what steps can you take to make sure you don't get into those situations alone, and to make sure your co-workers know what to expect of you?

_____
_____
_____

Fear of the Client's Behavior and Emotions

Many people find other people's strong and unpredictable emotions intimidating. They don't know what to do, what to say, how to respond, how they should feel, what's expected of them, or what's going to happen next. They feel as if the situation is out of control. It might remind them of situations in the past when emotions went out of control and they were hurt. It might bring up strong emotions of their own that they'd rather not think about or deal with.

People can also feel intimidated when others are silent, resistant, withdrawn, or emotionally "shut down." They feel as if it's their responsibility to break through the resistance, but it's not working. In either of these cases—if a new outreach worker is dealing with a client's emotional outburst or shut-down—the outreach worker's sense of responsibility for the client's emotions can make the situation particularly frightening.

What kinds of behavior and emotions (or lack of them) have you found most frightening or intimidating in clients and/or other people you've known?

_____
_____
_____

What might it be in your personality or your history that makes these emotional states hard to deal with?

_____
_____
_____

What ways have you found most helpful in getting through these rough spots?

_____
_____
_____

Unlike the safety fears described above, these are not the kinds of fears you can escape by going away and coming back later in the day with a co-worker. It's a natural part of the client's disease to be hostile, resistant, unpredictable, and out of control. These are fears you simply need to overcome, using whatever resources are available to you.

"If you're always afraid, you can't be an outreach worker," said one woman. "In the beginning it's just natural. But if you can't overcome the fear, then I think it's best to try to do something else, because you can't drive around scared." Outreach workers and supervisors recommend talking to your supervisor, and to other outreach workers, about your fears. Chances are they had the same fears in the early days. They can give you some perspective on your fears and hope for their resolution. They can also tell you what they did to overcome their fears.

Sometimes new outreach workers feel uncomfortable around clients whose ethnic and cultural backgrounds are different from their own. A client's behaviors and emotions might be normal in

her own culture, but in the outreach worker's culture they might signal danger or hostility. If you work with clients whose cultural background is different from your own, it's your responsibility to learn as much as you can about their culture. That way you can separate culturally normal behavior from signs of trouble.

If your fears are being intensified by your unresolved childhood issues, then you'll probably need therapy to work through those issues. If you come into the situation carrying your own baggage, you won't enjoy your work and you'll be cheating the client. You won't be seeing her needs clearly, because you'll be seeing her through the eyes of your own past.

While you're working on healing your fears, you still have to function in the outreach role. That involves learning to manage the fears that are still bothering you. There are two parts to managing these emotional fears. One is simply going ahead and doing what you need to do even though you feel afraid (again, we're not talking about safety-related fears here). The other is learning not to show the fear. "You can't appear scared when you come onto their turf, because they sense that," said a seasoned outreach worker. "If they feel you're scared, they'll bluff you, bully you—big time."

Another outreach worker told the story of a client who lived in public housing—below her family and above a drug dealer's apartment. When the outreach worker first came to her home, the client screamed and yelled and threw things on the floor, telling her to get out. The worker had to hide the fear she was feeling so that the client wouldn't believe she could chase her away. Then when they left the building, the client's personality changed completely. She grew calm and receptive and agreed to enter treatment. She simply had to put on a show of resistance in her apartment, to keep her neighbors from knowing she was going along with the program.

What other examples have you seen of clients using resistance and emotional force as a kind of "bluff" to hide or cope with their fears?

_____

_____

_____

How might it help you if you looked at many of their emotional displays this way?

_____

_____

Fear For the Client's or Her Children's Well-Being

Unfortunately, these fears are often well founded in reality. Many clients live on the streets or in violent housing projects; with violent paramours; and/or with a long history of self-destructive, abusive, neglectful, and/or violent behavior. Many have been exposed and continue to be exposed to HIV. Few clients have adequate preventive health care. Even clients who have adequate housing are living very close to homelessness. One relapse could easily eat the next month's rent money and result in eviction. If you didn't consider these very real possibilities, you'd be in denial.

What are some of your strongest fears for your clients' or their children's safety?

_____
_____
_____

What resources do you find most helpful in coping with those fears?

_____
_____
_____

Describe how you felt or might feel if a client . . .

. . . talked to you about suicide:

_____
_____

. . . hit or screamed at her children in your presence:

_____
_____

. . . chose to go home to a paramour who was angry and had a history of abusing her?

_____
_____

In your experience, what's the best way to deal with those kinds of situations if you're not sure what to do or how to respond?

_____
_____
_____

If these kinds of fears are difficult for you to manage, please read the module called "Empowering vs. Enabling." It will give you some help in responding to clients' self-destructive behavior. But as long as you care about a client, these kinds of issues are going to raise some fear in you, and you're going to grieve her pain and the damage to her life. The module called "Self-Care" can be helpful in that process.

What other resources are in your life that can help you cope with this "down-side" of caring for another human being?

_____

_____
_____

Fear of Personal Failure

Compared to the outreach worker's fear for the client's well-being, the fear of failure might seem like a selfish and petty fear, but it's not. Everybody has it. We all want to be good at what we do, be successful, and be recognized for that success. What's one thing that has happened (or might happen) in your work that you might respond to by feeling as if you had failed?

_____
_____
_____

Look at this situation more closely. How much of it is your personal failure, and how much is a combination of circumstances beyond your control?

_____
_____
_____

Many new outreach workers say they're afraid of low census—of having the clients not show up for treatment. One woman spoke about the summer of her first year as an outreach worker. Her program had been successful for months and months, graduating many women. Then the summer came, and they couldn't get anyone to stay more than two weeks. "And I would swear it was something that we weren't doing, or something that we were doing that was making them uncomfortable." Finally her supervisor called her in. After letting her talk and cry for a while, the supervisor simply asked, "Who wants to go to treatment in the summertime?"

That began the outreach worker's education in separating responsibilities. "I can't cure anybody—I can only support them and be there for them while they cure themselves," she said. The best defense against real failure is more education, more training, more guidance, and more support for your efforts. Beyond that, fear of failure is normal. Like a small dog yapping around your feet, the less attention it gets, the less likely it is to bother you.

Resources

A good resource for coping with fear in general is a book by Susan Jeffers called *Feel the Fear and Do it Anyway* (New York, Fawcet-Columbine, 1987).

2.4 Personal Style

Learning Objectives

1. Discuss the importance of being yourself in the outreach role and finding your own style and approach to outreach work.
2. Discuss some of the elements of an outreach worker's style (dress, accessories, tone of voice, body language, etc.) and what those elements might "say" to a client.
3. Discuss the personal style that you've developed in your life.
4. Identify the elements of your style that you've changed or modified—or might change or modify—to make it easier for your clients to be comfortable with you.

Being Yourself

The subject of an outreach worker's personal style can sometimes raise conflict because there are two very important considerations at work:

1. It's important for the outreach worker to be herself, both for her own comfort in the job and for her clients' comfort in working with her.
2. In most cases, the more your personal style sets you apart from the client, the harder it will be for her to trust you and see herself in you.

The first of these considerations was raised by a supervisor. "I just think that they [outreach workers] need to be comfortable in whatever approach they use, because the clients are so testy, and if they can sense that you're not comfortable in what you're doing, then they're going to push, push, push."

"Everybody has their own way of doing things, because what seems easy for you might be complicated for me. So you have to gradually get your own style, your own way of doing things."

But the second consideration can't be forgotten either. "Be respectable," said one outreach worker. "Be a role model for them. But the minute you dress up in a dress and stockings and look professional, they draw back. It's like we're now up here and they're down there. But if you wear the same attire that they're wearing—neat and clean—it's like we're buddy-buddy."

Another outreach worker brought up the importance of fitting into the environment in order not to make the client—and her involvement in the project—stand out. When you leave the building with a woman, it's better to look like her friend than her outreach worker. It protects her privacy.

In terms of personality, some outreach workers prefer to start out by matching the client's way of relating. "I'm very flexible," said one. "I kind of like go wherever that person is as far as her personality and her attitude." If the client is "soft," the worker takes a softer approach. If the

client is “hard,” the worker comes on a little harder.

Elements of Personal Style

Put yourself once again in the client’s place. For each point of style listed below, write a little about what that element of style tells you, the client—about the outreach worker, about yourself, about her attitude toward you, about what you can get away with, etc. Also note if any of these elements might remind you of past experiences with social service personnel, with the using culture, etc. Of course, not every client will see them the same, so look at them as most of your clients might tend to look at them.

Big words and complicated sentences:

_____
_____

Clean jeans and jacket:

_____
_____

Fearful looks and a hesitant tone of voice:

_____
_____

Flashy jewelry, a big diamond engagement ring, and a leather coat:

_____
_____

Always keeping quite a bit of distance between her and you:

_____
_____

Stern “mama” looks and an aggressive tone of voice:

_____
_____

Simple words, some street talk:

_____
_____

Standing or sitting very close to you when there’s room to spread out:

_____
_____

Worn-out jeans with holes in them:

_____
_____

A clipboard with a yellow pad on it:

_____
_____

A simple dress and flats:

_____
_____

A matter-of-fact tone of voice:

_____
_____

Heels and a tight mini-skirt:

_____
_____

Hair that hasn't been combed:

_____
_____

Lots of swearing and sexual language:

_____
_____

Laughing and playing with your kids:

_____
_____

Making a lot of jokes:

_____
_____

Rolling her eyes when she walks into your apartment:

_____
_____

Telling you many very personal things about her life and experiences:

_____

Speaking very slowly and carefully, exaggerating the way she pronounces her words:

A gorgeous, expensive suit:

Lots of sad looks and expressions of sympathy:

Fast, clipped tone of voice, very little emotion:

Again, not every client is going to react the same to any one of these elements of style. But it's important to get in the habit of looking at personal style from the client's point of view and seeing how it might affect your relationship with her.

Your Personal Style

Describe the personal style you've developed over the years:

Describe your style of dress and your hairstyle:

Describe your typical body language (in non-sexual situations):

Describe your general tone of voice when you're not upset:

Describe your usual facial expressions when you're not upset:

Describe your usual facial expressions when you are upset:

_____
_____

Describe the language that you use in most conversations:

_____
_____

Describe your sense of humor:

_____
_____

Modifying Your Personal Style

What elements of your personal style do you tend to change when you're with clients? If you're new to outreach, what elements of your style do you think you might try changing?

_____
_____
_____
_____

Are there any elements of your personal style that others thought wouldn't work with clients, but that ended up working well anyway?

_____
_____
_____

Are there any ways in which you find it hard to be yourself around clients?

_____
_____
_____

Who do you know who could help you work through those issues?

_____
_____

One final note: As you probably already know, personal style isn't something you can figure out intellectually and simply "decide" to do. Some elements of your style aren't going to change no matter who doesn't like them. And sometimes it's hard to be yourself even though you know that would be the best way to go. Your intuition, combined with information from your supervisor, your co-workers, and your clients, may be your best guide.

2.5 Learning About Addiction and Recovery

Learning Objectives:

1. Locate the major substance abuse-related training resources in Illinois.
2. Describe the process of worker certification within the substance abuse prevention and treatment field.
3. Identify key addiction-related texts.

What Do You Need To Learn?

Working effectively as an outreach worker requires a wide range of knowledge and skills. This includes an understanding of:

- the nature of addiction and the needs of addicted women entering treatment;
- families and communities;
- treatment, and the role that outreach services play in the treatment and aftercare process;
- recovery- and community-based resources that can support women in their long-term recovery; and
- the ethical and legal issues that can arise in the delivery of outreach services.

No outreach worker has all of this knowledge when he or she begins working. Working in the field is a process of ongoing education. In this module we will review the kinds of strategies and resources that can help you actively seek and make the best of this educational process.

Reading

<u>AIDS and Substance Abuse</u> (including approaches to AIDS case management)

Land, H. Ed. (1992). *AIDS: A Complete Guide to Psychosocial Intervention.* Milwaukee, WI: Family Service America, Inc.

Leukefeld, C., Battjest, R. and Amsel, Z. Eds. (1990). *AIDS and Intravenous Drug Use.* New York: Hemisphere Publishing.

<u>Case Management</u>

Moxley, D. (1989). *The Practice of Case Management.* Newbury Park: Sage.

Raiff, N. and Shore, B. (1993). *Advanced Case Management.* Newbury Park: Sage.

Counseling

Small, J. (1990). *Becoming Naturally Therapeutic: A Return to the True Essence of Helping*. Austin, TX: Eupsychian Press.

Zimberg, S., Wallace, J., & Blume, S. (1985). *Practical Approaches to Alcoholism Psychotherapy.* New York: Plenum Press.

Ethical Issues in Addiction Treatment (and Outreach)

Bissell, L. And Royce, J. (1994). *Ethics for Addiction Professionals.* Center City, MN: Hazelden.

White, W. (1993). *Critical Incidents: Ethical Issues in Substance Abuse Prevention and Treatment.* Bloomington, IL: Lighthouse Institute.

History of Addiction and its Treatment

Musto, D. (1968). *The American Disease: Origins of Narcotic Controls.* New Haven: Yale University Press.

Illinois' Response to the Needs of Addicted Women

White, W. (1990). *Project SAFE Program Handbook.* Springfield, IL: Illinois Department of Children and Family Services.

Introductory Textbooks

Brecher, E. (1972). *Licit and Illicit Drugs.* Boston: Little Brown and Company.

Kinney, J. and Leaton, G. (1991). *Loosening the Grip: A Handbook of Alcohol Information*. St Louis: Mosby.

Orientation to Addiction-Related Mutual Aid Groups

Alcoholics Anonymous (1955). New York City: Alcoholics Anonymous World Service Office.

Covington, S. (1994). *A Woman's Way Through the Twelve Steps.* Center City, MN: Hazelden.

Kurtz, E. (1979). *Not God: A History of Alcoholics Anonymous.* Center City, MN: Hazelden.

Kirkpatrick, J. (1986). *Goodbye Hangovers, Hello Life.* New York: Ballantine. (Description of the Women for Sobriety Program)

Relapse Prevention

Gorski, T. and Miller, M. (1982). *Counseling for Relapse Prevention.* Independence, MO: Herald House/Independence Press.

Special Needs of Addicted Women

Kasl, C. (1992). *Many Roads, One Journey: Moving Beyond the Twelve Steps.* New York: HarperCollins.

Roth, P. (1991). *Alcohol and Drugs are Women's Issues.* Metuchen, NJ: The Scarecrow Press.

Roman, P.M. (1988). *Women and Alcohol Use: A Review of the Literature.* Rockville, MD: U.S. Department of Health and Human Services.

Sandmaier, M. (1980). *The Invisible Alcoholics: Women and Alcohol Abuse in America*. New York: McGraw-Hill.

White, B. and Chaney, R. (1993). *Metaphors of Transformation: Feminine and Masculine*. Bloomington, IL: Lighthouse Institute.

Substance Abuse and its Treatment in Communities of Color

Trimble, J, Bolek, C. And Niemcryk, S. (1992). *Ethnic and Multicultural Drug Abuse.* New York: Haworth Press.

Williams, C. (1992). *No Hiding Place: Empowerment and Recovery for our Troubled Communities.* New York: HarperCollins.

Inservice Training

Most addiction treatment agencies provide regularly scheduled inservice training sessions to build the knowledge and skills of their direct service workers. We recommend that you actively participate in these sessions, and that you also take two more steps to get the most from these sessions: First, take notes on key points from each session; and second, keep a file of all your inservice training notes and handouts for future reference. This can be the beginning of your professional library. You can build that library through the years, and revisit it when particular issues or problems arise.

Outside Training

For the past decade, DCFS and DASA have sponsored special training sessions for people who work with addicted women who have histories of neglecting or abusing their children. Announcements of these trainings are sent to all funded women's treatment programs in Illinois. Be sure to tell your supervisor that you're interested in attending these training sessions.

There are other training resources that may increase your effectiveness as an outreach worker.

These resources can also prepare you for other roles in the addiction treatment field, if you're interested in pursuing them. Listed below are some of the addiction-specific training resources in Illinois and the contact person for each.

Academic and Clinical Training Programs

Dr. Joseph Troiani
Adler School of Professional Psychology
65 East Wacker Place, Suite 2100
Chicago, IL 60601
312-201-5900

Bill Green
African American Communiversal Project
P.O. Box 2783
Country Club Hills, IL 60478
708-798-6880

Rosemary McKinney or Frank Salvatini
College of DuPage
Human Services Program
22nd & Lambert Streets
Glen Ellyn, IL 60137
708-858-2800 Ext. 3050

Linda Wetherbe
College of Lake County
Human Services Program
19351 West Washington Street
Grayslake, IL 60030
708-223-6601 Ext. 2536

Director
Grant Hospital
Clinical Training Program for Addictions Counselors
550 West Webster, SE
Chicago IL 60614
312-883-3905

Billie Terrell, Acting Chairperson
College of St. Francis
Counselor Training Program
500 N. Wilcox St.
Joliet, IL 60435
815-740-3418 or 3360
815-740-3460

Kenneth P. Leisch
Danville Area Community College
2000 East Main Street
Danville, IL 61832
217-443-1811

Douglas Fraley
Elgin Community College
Human Service Department
Community College District #509
1700 Spartan Drive
Elgin, IL 60120
708-697-1000

Dr. Cheryl Mejta
Governor's State University
Addictions Training Center of Illinois
Governors Hwy., University Parkway
University Park, IL 60466
708-534-4911

Jeffrey Shore
Harold Washington College
Alcoholism & Substance Abuse Program
30 East Lake Street—Room 702
Chicago, IL 60601
312-553-6080

Illinois School of Professional Psychology
20 Clark St.
Chicago, IL 60602
312-201-0200

John Burian

Moraine Valley Community College
10900 South 88th Avenue
Palos Hills, IL 60465
708-974-4300

Felicia Dudek
National Lewis University
Alcohol & Substance Abuse Program
2840 Sheridan Road
Evanston, IL 60201
708-256-5150

Mary Ann Kubiak
Prairie State College
202 South Halsted
Chicago Heights, IL 60411
708-756-3110

Legia Ozeki
St Augustine College
1333 West Argyle
Chicago, IL 60640
312-878-8756

John Benshoff
Southern Illinois University
Rehabilitation Institute
Carbondale, IL 62901-4609
618-536-7704

Abdul Mannan
601 James Thompson Boulevard
East St. Louis, IL 62201-1129
618-583-2550

Thomas Delegatto
Triton College
Basic Addiction Counseling Program
2000 Fifth Avenue H-Building
River Grove, IL 60171
708-456-0300 Ext. 3428

Susan Scrimshaw
University of Illinois at Chicago
School of Public Health
Office of Dean
2121 W. Taylor St.
Chicago, IL 60612
312-996-6620

Joan Flanagan
Waubonsee Community College
Route 47 at Harter Road
Sugar Grove, IL 60554
708-466-4811 Ext. 467

Training programs that provide workshops and seminars for personal/professional development and for maintenance of Continuing Education Units (CEUs) for certification:

Jan Gomien
Academy of Addictions Treatment Professionals (AATP)
2300 Willemore
Springfield, IL 62704
217-787-9321

Gateway Training Academy
St. Louis, MO
314-421-6188

Susan Basile, Coordinator
Continuing Education
Haymarket House
Summer Addictions Institute
120 N. Sangamon
Chicago, IL 60607
312-226-7984

Irene Gainer, Executive Director
Illinois Alcohol and Drug Dependence Association
Annual Conference
937 South 2nd Street
Springfield, IL 62704
217-528-7335

Bill Johnson, Director
Illinois Alcohol and Other Drug Abuse Professional Counselors Association
1305 Wabash, Suite L
Springfield, IL 62704
800-272-2632

Michael Moran
Interventions
2221 W. 64th St.
Woodridge, IL 60517
708-968-6477

Randall Webber
Lighthouse Institute/Chestnut Health Systems
720 West Chestnut Street
Bloomington, IL
309-827-6026
Internet: www.chestnut.org

Dr. Robert Hotes
Prevention First, Inc
2800 Montvale Drive
Springfield, IL 62704
217-252-8951

Getting Certified

You might want to work toward getting certified as you build your education, training and work experience in the substance abuse treatment field. In Illinois, certification of workers in the field is administered by the Illinois Alcohol and Other Drug Abuse Professional Certification Association—commonly known as IAODAPCA.

IAODAPCA provides certification under the following classifications:

Provisional Alcohol and Other Drug Abuse Counselor
Certified Alcohol and Other Drug Abuse Counselor
Certified Reciprocal Alcohol and Other Drug Abuse Counselor
Certified Supervisor Alcohol and Other Drug Abuse Counselor
Certified Master Alcohol and Other Drug Abuse Counselor
Certified Assessment/Referral Specialist
Certified Alcohol, Tobacco and Other Drug Abuse Preventionist
Certified Senior Alcohol, Tobacco and Other Drug Abuse Preventionist

Certifications are granted based on a combination of qualified work experience, education, training, and supervision. The certification processes are slightly different for different classifications, but in general you'll need to prepare a portfolio application, pass a written test, and complete an oral case presentation. You can get information on application procedures and costs by writing or calling the Illinois Alcohol and Other Drug Abuse Professional Certification Association, 1305 Wabash Ave., Suite L, Springfield, IL 62704 (800-272-2632).

Journaling

Before closing this module on professional development resources, we'd like to offer one more suggestion that many people have found very helpful in enhancing their personal and professional development as outreach workers. Journaling is a technique of self-mentoring that can capture fleeting perceptions and insights. Journaling can also serve as a documentation of your own development as an outreach worker.

Different people use different journaling techniques, depending on their needs and what works best for them. In general, journaling involves keeping daily, weekly, or occasional notes on ideas, incidents, observations, and your own feelings about things that happen during your work as an outreach worker. Journaling is a way to form a ritual around periods of self-reflection about your work, and a way to help you step back and make sense of what you're seeing, doing, and experiencing. Journaling can also be a form of self-therapy, helping you get through some of the most difficult parts of the outreach process.

2.6 Realistic Expectations

Learning Objectives

1. Discuss the program-wide evolution of realistic expectations for the success of Project SAFE clients, and compare those expectations with your own experience.
2. Identify your own expectations of your clients, and discuss how those expectations have changed during your time as an outreach worker.
3. Discuss some specific realistic expectations that outreach workers have defined.
4. Discuss the difference between *expectations* and *hope*, the effects of these two concepts on your work, and ways of keeping hope alive while expectations change.

Expectations in Project SAFE

When Project SAFE began, the staff's expectations and definitions of client success were very high. Child abuse and neglect would be eliminated. Clients would learn to function well in their roles as parents. The families would stay together or be reunited. Clients would stop abusing alcohol and other drugs. The physical and emotional health of clients and their children would be improved.

Since then the realities of clients' lives—life-long histories of pain and hopelessness, the presence of multiple disorders, the lack of even basic life skills—have moved those expectations to the position of long-term goals. We now understand that recovery for these women is a long-term developmental process. It has to wash over them in waves, each time sinking in a little more and carrying them a little farther. Getting clean and becoming a responsible parent might take many episodes of treatment and recovery. But the first time through treatment is just as important to that process as the last.

In 1994, a group of Project SAFE and DCFS staff members came up with a new goal statement: "Our goal (related to substance abuse) is to enhance each woman's long-term capacity for recovery by helping her grow as much as she can at this point in time." This goal included starting her off on sobriety, replacing neglectful and abusing behaviors with healthy ones, and planting the seeds for long-term recovery and effective parenting. "Even if she relapses, she's farther along toward establishing long-term recovery than she was before she got here. Her capacity for eventual recovery and the family capacity for healthy functioning has been enhanced." (SAFE 94, p. 41)

When they were asked what Project SAFE has been successful in accomplishing, these staff members said:

- "We provide a safe, substance-free environment in which each woman can reassess her life."
- "We provide a non-judgmental, hope-filled environment that encourages healthy change."

- "We break the cycle of dependency by cultivating both the spirit and the skills of independence."
- "Project SAFE saves lives."

How do the expectations, goals, and accomplishments described above compare with your experience in Project SAFE? (If you're new to the project, compare them with what you've been told about project expectations.)

_____
_____
_____
_____

Have staff members' expectations of client success changed because of the system-wide rules limiting the amount of time clients can spend in intensive outpatient treatment to 75 hours? If so, how have they changed?

_____
_____
_____
_____

Expectations of Your Clients

Think of a client who's fairly new to you. Write her name and briefly describe her present circumstances:

_____
_____
_____
_____

Describe your current expectations of this client's behavior—how you expect her to act, what you expect her to say, etc.:

_____
_____
_____

Describe your expectations of whether or not this client will graduate and what she will accomplish by the time she leaves your program:

_____
_____
_____

Think for a minute about the expectations you've had for your clients during your time as an outreach worker. Name any expectations that have been disappointed more than once:

Have those expectations changed? If so, what are your expectations now?

Outreach Workers' Experience

Here are some thoughts provided by other outreach workers who have seen their own expectations change over the years:

- It's important to remember that each client is different. What works with one client may not work with the next. You need to approach each situation with an open mind and not pre-judge the client based on others clients, or on her referral paperwork.
- You can expect resistance from a client at first. If it's not there, you're probably getting hustled.
- You can't expect the truth from a client when lying has always been her main means of survival. You can't expect her to open up to you about her family if her culture has taught her not to do that.
- Most clients have never had much reliable structure in their lives, and many have never had jobs. They find it hard to wake up at a certain hour and prepare for group, get their children ready, do their housekeeping, and do basic self-care.
- It's important to have realistic expectations for the children too, and to communicate those expectations to their mothers. In most cases the children had no structure before and no consistent rules to follow. Now that their mothers are getting better, the children have new rules to follow. This can cause confusion and rebellion. The clients need to help their children understand the changes they're going through in the program, so they can work through those changes together.
- If the client has custody of her children, and the outreach worker comes to care about the children, that can raise the worker's expectations of the client. It can test the outreach worker's tolerance and anger-management skills if the client continues to use while she's responsible for her children's well-being.
- Outreach workers who are in recovery may be particularly vulnerable to unrealistic expectations based on their own success in recovery. If you find yourself pushing clients in one way or another, look at your expectations and the sources of those expectations.
- It's just as important to have realistic expectations of yourself. You aren't a super hero.

If you try to be one, you'll end up making even more mistakes and burning yourself out. Then you won't be able to help anyone.

- It's important to see and celebrate the small successes, rather than hold yourself or the client to impossible standards.
- Clients need to hear about it when they're doing well. They need to know you notice that they're coming in every day, having negative drops, and doing well in the program. Their own expectations of themselves might be unrealistic, so you need to call their attention to their own small successes.

Are there any of those statements that you've found not to be true in your work? If so, which ones and why?

_____
_____
_____
_____

What thoughts of your own can you add to that list?

- _____
  _____
  _____
  _____
- _____
  _____
  _____
  _____
- _____
  _____
  _____
  _____

Expectation and Hope

Many people in the helping professions struggle with this question: When I have to keep my expectations reasonable, how do I keep feeling—and conveying to my clients—a sense of hope?

First a quick, informal definition of each term. *Expectation* is what we think will happen. If you turn on the water, you *expect* water to come out. If you drive 65 miles an hour past a cop in a 35-mile-an-hour zone, you *expect* to get pulled over. Just because something is your expectation, that doesn't mean it's good or bad. It's just your best guess at what will happen.

Hope includes all the things you want to happen that are somewhere in the range of possibility. We hope they'll come up with a cure for AIDS tomorrow, but we don't hold out the hope that we'll wake up tomorrow and AIDS will never have happened. We might wish that, but we know enough not to hope for it.

Hope is the most important thing that Project SAFE has to offer. You are, as one outreach worker put it, "the voice of hope" in your clients' lives. As important as it is to have reasonable expectations for your clients' progress, it's just as important to have unreasonable hopes.

Hope is like faith. It's not based on logic or on our observations of what's reasonable to expect right now. It's based on things we can't see or completely understand. In your own life, in your clients' lives, and in the lives of people you love, you've probably seen positive changes that you can't explain logically. Those are the things that hope is based on.

We all feel more hopeful some days and less hopeful on other days. When you're feeling hopeful, what message does this give to your clients?

_____
_____
_____

When your clients pick up on this message, how do they tend to react?

_____
_____
_____

When you're not feeling hopeful, what message does this give to your clients?

_____
_____
_____

When your clients pick up on this message, how do they tend to react?

_____
_____
_____

Please describe your best hopes for your clients:

_____
_____

_____
_____
_____

What words do you use to tell your clients about those hopes, and what other words might you use?

_____
_____
_____
_____

How do you convey those hopes to your clients without using words, and what other ways might you try?

_____
_____
_____
_____

How are you going to keep your hopes high and alive while you keep your expectations realistic?

_____
_____
_____
_____
_____

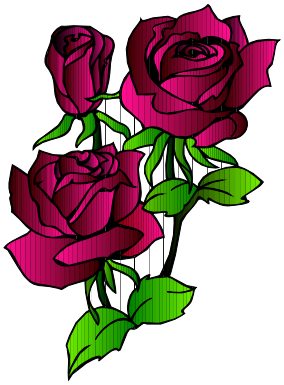
Who do you know who gives you a sense of hope, and how might you learn from what they do?

_____
_____
_____

Don't Give Up

D. Banks MacKenzie of the Appleton Home in Boston, Massachusetts was quoted in the 1870-1875 Proceedings of the American Association for the Cure of Inebriates. He offered the following advice to people who work with addicts—words that are as valuable today as they were then:

". . . do not be hasty in giving up a victim as incurable. Your patience will be sadly tried, those you had the most confidence in will betray you, lie to you, deceive you and fall. Do not give up, forgive seventy times seven. So long as the prodigal comes back, acknowledges willingness to try again, the spark is there. This is a work of great trial but great rejoicing . . . the good seed is planted, and will bring forth fruit sometime."



Section 3.0
Outreach Worker Functions

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3.1 Client Engagement

Learning Objectives

1. Define “client engagement.”
2. Describe the hope/pain synergism.
3. Describe five essential facets of the engagement process for addicted women.
4. Discuss why it’s important to engage other important people in the client’s life.

Definition

Engagement is the process of persuading a client to participate in treatment. She is engaged when she enters treatment and disengaged when she "drops out" against staff advice.

The Client's Perspective on Entering Treatment

After reading the following excerpts from outreach interviews, list the client’s reasons for resisting treatment. Add to this list from your experiences or expectations.

> *Fear of change and just not knowing what to expect, and then they have low self-esteem and they don't think that they deserve these things anyway. So, in order for them to begin to trust, they have to see that “it’s okay for me to accept this.” Because in their lives they've always had to give something in order to get something. Nothing came easy. And recovery doesn't come easy. There's a price you have to pay for it.*
>
> *The bottom line is that DCFS has mandated them to do this, and any time you're mandated to do something, there's a level of resistance.*
>
> *I went to get her one day...They were sitting in the kitchen shooting up, you know? She...put her arms around me and she said, "This is too big for you. You're wasting your time. I want to do it. Look at that. I'm going to be this way for the rest of my life."*

From the client's perspective, what would be her reasons for resisting treatment?

_____

_____

_____

_____

The Hope-Pain Synergism

You can measure the likelihood of successful engagement of a client by looking at the *hope/pain synergism* in her life—the ratio of hope (of the benefits of recovery) to pain (of the consequences of addiction). Where there is high pain and high hope—something that rarely happens in Project SAFE clients' lives—engagement can be quick and intense. Where there is low pain and low hope, there's very little chance that she will enter treatment.

It's in the combinations of high pain/low hope and high hope/low pain that the intervention technology of outreach is most important. In these cases, by letting persistence and consistent positive regard work their magic, outreach can change the equation and get the client engaged in treatment.

Early in their treatment experience, addicted women tend to have intensely conflicted feelings about treatment. Clients keep a foothold in both worlds—addiction and treatment—gingerly testing each step forward and backward. In this transition period we find strong patterns of thought and emotion that don't make sense or fit together. Examples of these kinds of contradictions include clients who want to keep using drugs **and** keep coming to treatment, and clients who want staff to go away because staff make them feel good and hopeful.

While some clients might express this kind of ambivalence in subtle ways, most often they play it out in dramatic behavior, like missing days in treatment, splitting in anger and then calling to get back in the Project, relapse behaviors, etc. True emotional engagement is rarely a bolt-of-lighting event. It's much more likely to be a slow process, with every stage marked by behaviors that may test you and the other staff members.

The Hope/Pain Matrix

High Pain HP	Low Hope LH	HP/LH is the most typical initial pattern encountered with SAFE women. External control and hope-engendering relationships are the key ingredients in treatment engagement
High Hope HH	Low Pain LP	HH/LP represents the honeymoon phase in the drug relationship. The drug relationship is experienced as a 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 the post-honeymoon phase of the drug relationship. Trust building by outreach workers can set the stage for treatment engagement during future crises.	

Dimensions of Engagement

Experience in Project SAFE in Illinois has allowed outreach workers to identify and describe a number of critical dimensions of engagement.

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.

In the beginning, they're very resistant. They don't trust. They see us in the beginning as the enemy, like we're working hand-in-hand with the child welfare agency and the only goal is to take their children. So they are resistant, they're angry, they're full of a lot of anger. A lot of moms are resistant about child care because they think we're going to take their babies to the child care and the child welfare agency will pick them up from the child care place.

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.

Ability to Listen

They can't hear you until you've heard them. The trick is to shut up and listen until they're ready to hear what you have to offer.

I think it's the first time they've been listened to and not judged.

So you have to show them that you care. And loving and listening. If it takes dropping a client off and sitting outside her house for half an hour and letting her dump a lot of stuff on you, that's what you have to do...Just listen; let them talk.

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.*

We're from the neighborhoods. We've lived in ...public housing sites. You go to the same stores that they do. You already know what they're going through. It's not like they have to hide anything. You may have been standing right there watching them when they got arrested. Or watching them...down at the bottom of the barrel so to speak. And they already know that you know this about them.

Empowerment *Its 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 keep 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."

Lack of Judgmentalism *You can't be judgmental. You have to be willing to allow the clients to make mistakes and to be resistant, because that's what they are.*

When you do outreaching, one thing you need to do is be an equal. You have to let the client know that you're no better, that you're her equal.

Refusal to be pushed away *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.*

[I say 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	[I break through the resistance by] *not giving up. Keep knocking on their door. Keep calling; say "I'm just calling to see how you're doing." They get to the point where they want to get you off their back. They just surrender. They finally realize that we're not going to let off. That we'll keep at it until we give them the help they desperately need.* *They have to know you care enough that you won't give up.* *"She's not here? Tell her I will be back many times."*
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!* *I'm like a parent. In the beginning I tend to be really stern. Once the client is engaged, I can relax a little and work with that. When they backslide I may have to be a little more stern.*

Individual Differences

Obviously, not every engagement dimension will be useful with every client. As other outreach workers have reminded us, it's important to remember that each client is different. You can't expect that a technique that worked with one woman will necessarily work with another woman. It's important to approach each new case with an open mind and seek out what motivates that particular woman. As part of this process, the outreach worker needs to assess how the woman is feeling about everything going on in her life at that point in the intervention.

Some sites have offered tangible rewards to motivate clients. For example, one site gave a woman a sitting for a portrait of her and her family when she completed treatment. Other sites have used personalized attendance logs or highly visible attendance charts, on which clients get stars for attendance. When they get enough stars, they can redeem them for various gifts. Still another site has given women welcome kits that include a number of toiletries and other personal

items.

What might be some other tangible and intangible ways to motivate individual clients?

_____

_____

_____

Engaging the Whole Family

Enabling and sabotage by family members, paramours, and other drug-using peers is a significant obstacle for drug-addicted women. When Project SAFE began, many outreach programs concentrated on the client and the children. But now outreach workers are saying that their focus has grown wider. The influence of ASAM criteria has increased their emphasis on working with more family members in order to build a stronger support system. The general experience in treatment used to be that many women would leave without a support system to return to; this was endangering all the gains made in treatment.

Engaging the children seems to be an easy and enjoyable task for outreach workers. Many transport children daily. This provides an opportunity for interaction and building a relationship. Many children look forward to the child-care experience; they tend to see the outreach worker in a positive light because she provides transportation to child care. One worker noted that the children get so excited about what they're planning to do in child care that they make their mothers get up in the morning and go to treatment so they won't miss the child-care experience.

Engaging other members of the family may be more difficult. Some outreach workers have reported that they don't work much with other family members; their agencies discourage family involvement in order to maintain confidentiality.

After some thought, write down what you believe the role of an outreach worker should be in engaging children, paramours, and other family members along with addicted women.

_____

_____

_____

_____

_____

3.2 Problem Solving Around Obstacles to Recovery

Learning Objectives

1. Name two major obstacles to recovery.
2. Identify ways in which outreach workers can help clients overcome each type of obstacle.

The Obstacles

Of all the obstacles to women's ability to enter and complete treatment, the most frequently mentioned is the lack of safe, accessible, and affordable child care. Lack of safe and drug-free housing is also a significant barrier for many women. Many fear the loss of their housing if they enter residential treatment settings. Throughout the history of traditional treatment programs, many women who were motivated to succeed would fail because of one or both of these obstacles. A major part of the Project SAFE outreach role is the task of helping clients overcome these obstacles.

Child Care

One client talked about all the work her outreach worker did in helping her solve child-care problems:

> *She worked very hard, you know, trying to get things worked from there for my twins. See I have a set of twins, so I have to take them to day care. So she worked very hard to get that done, cause since I was going to be coming here to the SAFE program. So she was very helpful with that, and I did my part too. You know, I had my part that I had to do, but, she was very—you know—outgoing and stuff.*

The following are examples of how outreach workers help women find and maintain child care. Add to the list from your own experience:

1. Regularly transport children to the child-care provider.
2. Locate appropriate child care if it's not provided by the agency.
3. Negotiate with the child-care worker whenever issues arise between the mother and the provider, or if there's any question about the appropriateness of care.
4. _____
5. _____
6. _____

One outreach worker said that she has a whole list of different day-care agencies in her community and the hours they're open—including agencies that are open 24 hours a day. She's checked out whether or not they'll take children by the hour while their mothers are in outpatient

treatment. Her most difficult challenge has been finding day-care slots in evening programs.

Housing

When we asked Project SAFE staff about housing, we quickly found out what a serious obstacle the lack of housing could be. The staff members had much more to say about the problem than about possible solutions. Here are some quotes from case managers:

> *It's hard for them to get housing. I mean, your chance of getting a job, getting hired on the job, when you're saying "I can't come this day, this day, this day because I'm in treatment." Once you tell the employer that, he's getting rid of you—or he's not going to hire you. So you don't have the money to get a place of your own. You don't have income if you don't have your kids. I've always said—and I believe—that's a setup for them to fail. To take their kids and tell them, "before you get them back, you need to get housing. You gotta complete treatment." "Well, I can't complete treatment and work, so I'm not going to get a place, which means we're running in this triangle here where I'm never going to get my kids back, because you set me up to fail." Yeah, they got the program that'll help them get a place, but it's only for so much money. Unless they're getting public housing, the money that they're going to give them to support them to get a place is not enough, because you got people with 2 and 3 kids, and you're asking them to pay $350-500 a month plus utilities. They can't do it. Not even on public aid, they can't do it. So you've set them up to fail. Nine out of ten times, they got kicked out of public housing because of the drug use, they weren't paying rent, or they let the drug dealers use their apartment—they got busted for drugs. They can't get back in there. . . I wish we could get the money to build our own halfway house.*
>
> *I had one instance where the housing coordinator wanted me to assure her—because they were trying to make these places drug free—that if she put that client there she would not use. She wanted me to verify that she would not use. I said that I can't do that,* [although] *that's our hopes.*
>
> [Housing has] *been a struggle because I've seen women who were living in conditions that were very inhumane. Having some knowledge about what DCFS offers, and the difficulties with the clients' not having adequate history—any credit background—they can't really find decent housing. The money is available, but how do you get linked with the service that will allow you to be able to afford the rent? You can't pay, even though they're willing to give you the normal funds to pay part of it. I have a client right now who belongs to that particular group. And what I've done to try to help her is to give her some resources as far as numbers to call and try to investigate the possibilities. They get discouraged very easily, so I try to encourage them. How important is this? She has three children, girls, and she really wants her children to have a nice place to live. When you get discouraged, I say, "just look at your babies."*
>
> *For the homeless, it's good to know places you can refer them and recommend. A lot of our women who have graduated through Project SAFE come out of Cabrini-Green; and you figure, they have a program, and now they're in recovery, and they have to return to Cabrini-Green. There's really no other way they can get out of there for the money that they're paying. It would be great if we could send them somewhere; that would help*

their recovery a lot.

If they are in the projects and they don't have a lot of income, we tell them that maybe they can get an apartment. We encourage shelters until they can get on their feet.

What solutions have you found to housing problems in your community?

_____

_____

_____

_____

3.3 Home Visits

Learning Objectives:

1. Describe the purpose of home visits during the engagement and treatment phases.
2. Describe a number of things an outreach worker might do during a home visit.

The Purpose of Home Visits

The engagement process usually begins with a home visit, because this is often the outreach worker's first opportunity for contact with the client. Many outreach workers find that, on their first visit to a client, she isn't home or it's hard to get her to open the door. When clients are in treatment, most receive at least two home visits from their outreach workers.

In the words of one outreach worker:

> *The purpose of the home visit is to assess the client, the client's home life, the way they interact with their children, whether they have homemaking skills.*

What Goes On in a Home Visit—or—"You can't be a wimpy outreach worker!"

Here is how an outreach worker described the first home visit to a particular client:

> *You get a referral from a DCFS worker and you get a client appointment. You write a letter and go the client's house. The first time, the client is usually not there—usually* ***always*** *not there. So you leave a letter and then you go out the second time and see the client. You talk to the client and explain that "I'm* [name] *and I'm an outreach worker for* [agency]. *A DCFS worker gave me a referral. She or he wants you to have an alcohol and drug assessment."*
>
> *And they say, "What does that mean?" "It just means that you come in and you're going to be asked some questions, and possibly you might have to take a drop, but I'm not sure. I'm not going to say that you are going to have to when you're not going to have to." But these are some of the things. . .and they ask, "Is it inpatient?" "No, it's outpatient." "Well, how am I going to get there?" Then I say, "Slow down and let me explain it to you first, and then if you have questions, you can ask."*
>
> *I tell them it's an outpatient program. "It's five weeks, Monday through Friday. You get picked up, dropped off; you get child care." Then you can see they go from mad to laid-back, and they start to listen more.*
>
> *I say "We pick you and the kids up and drop you all off, and if there's anything that we can do to make you being in treatment easier for you, that's what we're here for." "Well, where do I go?" "Here's a letter, and this is the time of your appointment. I'm going to pick you up at this time so that you can be sure to be there for the appointment."*
>
> *Then I tell them they have to take the kids to the doctor in order for them to get the child*

care. "Well, how will I get to the doctor?" And I tell them I'll call their DCFS worker and maybe the worker can bring them some tokens so that they can make the meetings, take the kids to the doctor. "Other things that maybe we can't help you do, we draw in your DCFS worker and they help you."

So, they come here for the intake and they'll still be kind of leery, but once they start, they open up more. You have to rehearse it—you have to stay focused and take a lot of the bad things that they're going to say, a lot of punches. But you have to remain calm and at the same pace, because if you don't, that's it. You've lost them. If you don't hold their attention and do what you have to do to grab them and bring them in, you've lost them. You can't be a wimpy outreach worker: there's no such thing as that.

A client talked about a home visit this way:

One time she came to my house and I was going through, like, a grieving process, and she ... convinced me to come into the center to talk to my counselor, something that I didn't want to do.

The following are descriptions of actual home visits:

The following is an example of a home visit I went on today. I parked around the corner so she wouldn't see the van. I walked to the house and rang the bell and she immediately came down and she brought me upstairs. I think she's living with her boyfriend. I'm observing the house. I suspected she was high. She had her daughter over for visitation. The daughter was so dirty, you know. I'm scanning this place—for a safety factor, because I'd never met this guy. I don't really know what's going on. So I ask her about her lack of attendance. It's really amazing. A lot of them will look you right in the face. Her eyes were really glassy. I could tell she was bombed. It lasted for about 15 minutes.

I have a list of questions that I go through. [If] *they used during the week. . .If the bathrooms are clean, then—if the house is clean. Then I also see if there are burns on the furniture—which is my own observation—if the kids are dressed in clothes that they've slept in, or if they have clean clothes on everyday, if their faces are washed, if their dental needs are met.*

Yesterday, I did a home visit and it lasted an hour and a half. We went through family albums because I happened to know one of her uncles used to date one of my cousins. She got out the whole big book and showed it all to me. Just sitting there doing things like that, she said, "I never have had company before without getting high until I started coming to Project Safe. This is fun."

The above examples illustrate only a few of the tasks outreach workers do during home visits. Outreach workers also said they provide suggestions about keeping house and grocery shopping, and they talk with the children to supplement what the parent has said about what is going on in the household. Are there any other things you've done on a home visit, or heard others talk about, that aren't mentioned in the examples above? If so, please write them below:

_____

_____

_____

_____

Practice

It's your **first home visit** with a woman. List the topics that need to covered during the visit and observations you want to make.

1._____

2._____

3._____

4._____

5._____

6._____

7._____

Now, using your list as a guide, role-play your first home visit with the help of another person (preferably an outreach worker or other Project SAFE staff member). When you've finished the role-play, ask the other person for feedback on your performance.

Now make a list of topics you want to cover, and observations you want to make, on a home visit to **a woman who is already active in treatment.**

1._____

2._____

3._____

4._____

5._____

6._____

Using your second list as a guide, role-play this type of home visit with another person, then ask for feedback on your performance.

What would you do if...?

1. You get to a client's house, her small children are in the house by themselves, and she's nowhere around.

   _____

   _____

2. There's no place to sit in the house that looks clean or uncluttered, and out of the corner of your eye you see things crawling around.

_____

_____

3. The client has been getting more independent, you've sensed that her paramour has started feeling threatened by this, and when you go for a visit you see that she has two black eyes.

_____

_____

4. You go to visit a woman and she slams the door in your face.

_____

_____

5. You get to the house and see that there are people in the other room shooting up.

_____

_____

3.4 Monitoring Abuse and Neglect Issues

Learning Objectives

1. Define “child abuse” and list the types of acts considered by law to fall in that category.
2. Define “child neglect” and list the types of acts considered by law to fall in that category.
3. Describe three ways you might monitor abuse/neglect in your outreach role.
4. List the procedures prescribed by your agency for responding when you suspect abuse or neglect.
5. Using the definitions of abuse and neglect, evaluate examples seen by outreach workers.

Definitions

The Illinois Abused and Neglected Child Reporting Act (P.A. 81-1077, effective July 1, 1980, as amended, defines an “abused child” as:

- a child whose parent or immediate family member, or any person responsible for the child’s welfare, or any individual residing in the same home as the child, or a paramour of the child’s parent:
    a. inflicts, causes to be inflicted, or allows to be inflicted upon such child physical injury, by other than accidental means, which causes death, disfigurement, impairment of physical or emotional health, or loss or impairment of any bodily function;
    b. creates a substantial risk of physical injury to such child by other than accidental means which would be likely to cause death, disfigurement, impairment of physical or emotional health, or loss or impairment of any bodily function;
    c. commits or allows to be committed any sex offense against such child, as such sex offenses are defined in the Criminal Code of 1961, as amended, and extending those definitions of sex offenses to include children under 18 years of age;
    d. commits or allows to be committed an act or acts of torture on such child; or
    e. Inflicts excessive corporal punishment.

According to the same law, a “neglected child” is:

- any child whose parent, or other person responsible for the child for the child’s welfare:
    a. withholds or denies nourishment or medically indicated treatment, including food or care, denied solely on the basis of present or anticipated mental or physical impairment, as determined by a physician acting alone or in consultation with other physicians;
    b. does not provide the proper or necessary support, or medical or other remedial

care recognized under state law as necessary for a child's well-being, including adequate food, clothing and shelter;

c. who is abandoned by his or her parents or other person responsible for the child's welfare; or

d. who is a newborn infant whose blood or urine contains any amount of controlled substance as defined in the Illinois Controlled Substances Act or a metabolite thereof, with the exception of a controlled substance or metabolite thereof whose presence in the newborn infant is the result of medical treatment administered to the mother or the newborn infant.

Monitoring Abuse and Neglect

The following are examples from the interviews with outreach workers of how they monitor abuse and neglect. Add to the list from your own experience:

1. Observe the home environment for cleanliness.
2. Monitor the behavior of the women toward their children in the van/car.
3. Look for outward signs such as scratches, bodily marks, a man lying around the house.
4. Listen and look for issues with food in the home or in the van. Signs of these issues might include the absence of food in the home, extreme hunger on the part of a child, a client's withholding food from her child as punishment, etc.
5. Assess whether children are dressed properly for the weather, or whether their clothes might be intended to hide bruises or scars. As one outreach worker said, "If it's a warmer day and she's got a turtleneck with long sleeves, something's not right."
6. Assess whether or not there are signs that the woman might still be using. For example, is she clean, or is she still wearing the same clothes she wore to group the day before?
7. See if the children are clean. Are they dressed in clothes that they've slept in, or do they have clean clothes everyday?
8. _____
9. _____
10 _____
11. _____

What procedures do you follow in your agency if you suspect child abuse or neglect? For example, would you make the report to DCFS? Would you always discuss the situation with your supervisor before you made the report?

_____

_____

_____

The following are examples from actual home visits. After reading each, decide whether or not you believe it's an example of abuse or neglect. If you believe it is, write whether you believe it's abuse or neglect, and provide the letter(s) describing the type of abuse or neglect from the statutory definitions listed above. Also, tell what you think should be done in that situation.

I made one home visit where these kids had bruises from the bottom of their feet to the top of their heads. Everywhere. One of the kids asked me if I wanted something to eat. And I said "No, thank you." And he said he was hungry and he went to the kitchen, in the refrigerator, and got a can of dog food and started eating it. And the lady was so embarrassed she grabbed the can and whooped the boy.

_____

_____

_____

One lady, her house was real clean. She had a mousetrap about this big, and the little kid was playing with it. That little boy could have broke his hand when that trap popped. It was a big trap, a huge trap. It was a little kid, about one year old.

_____

_____

_____

I went to do the home visit. It was in the neighborhood. I went to the house. The children were in the house and I could see that it was a basement apartment. I kept asking, "Where's your mother?" Finally, the little boy who I think was two years old answered the door. I walked in the apartment and the mother was knocked out. She looked like she had been using for days.

_____

_____

_____

We had an incident yesterday where, I guess, the living conditions weren't very good. The roof fell in.

_____

_____

The home was so bad. There were feces on the floor. . . from the dogs and the baby diapers.

_____

_____

Reading Resources

Child Abuse and Neglect Statistics: Annual Report—Fiscal Year 1994. (1995). Springfield, IL: Illinois Department of Children and Family Services.

3.5 Providing Transportation

Learning Objectives

1. Explain the importance that transportation plays in the treatment of addicted women.
2. Describe the types of trips that are acceptable for your agency.
3. Describe three ways that the outreach worker can support clients' treatment while providing transportation.
4. Suggest a set of rules that would be appropriate for use in the agency van or car.

Role of Transportation

DCFS offices and local treatment agencies often cover large geographical areas. This makes it difficult for most women to get to treatment. In urban areas, safety issues often make the use of public transportation difficult or inadvisable. Some women also have to get children to child-care providers in order to attend treatment. For these and other reasons, the lack of transportation is a major obstacle that many women need help to overcome before they can participate in substance abuse treatment.

Strategies for helping women overcome this obstacle have included providing bus passes to clients to get to treatment, organizing client car-pools, and tapping the resources of local health and human service transportation services.

More often, outreach workers provide the needed transportation to and from the treatment agency, self-help meetings, and other destinations. They do this in agency vehicles (sometimes in vans), or in their own cars.

Clients often talk about the transportation aspect when they describe their outreach workers. For example:

> *She . . . is more involved with us, you know, as far as, you know, taking us around to do our business, picking us up, bringing us to group . . .*
>
> *She took me to the stores and things that I had to do, like carrying me, going with me to cash my check and different things . . . she was always very patient with me, like if I had to go to a whole lot of different stores, she was willing and she never, you know, like rushed me, or "hurry up," you know.*

Destinations

Different agencies have different policies and practices regarding transportation. Check any of the following destinations you typically take clients or their children to:

__ Outpatient treatment

__ Social Security Office
__ Medical office (for the women)
__ Medical office (for the children)
__ Job interviews
__ Grocery stores
__ Child care centers
__ Schools or training sessions
__ Self-help groups
__ To buy clothes (for the women)
__ To buy clothes (for the children)
__ Assessment interviews
__ Other_____
__ Other_____
__ Other_____
__ Other_____

What else happens (besides getting there) during transportation?

When we interviewed outreach workers about transportation, we found out that clients often viewed the van as a "safe place" where they felt comfortable and often revealed things that they didn't talk about in traditional treatment settings. Outreach workers reported that they sometimes suggested going for a ride in the van to talk things over, if the client's home didn't offer privacy or safety. Another worker described a woman who was totally different (more cooperative) when she was in the van than when she was in her home or around other people. How can outreach workers help while they're providing transportation? Below are examples of how some outreach workers have tried to make van or car rides an extension of the engagement and treatment experience:

Encouragement

If they finally hook into the outreach worker when she shows up on their door (a lot of times for the 10th or 20th time), then we'll get them and they'll stay with us. A lot of that is the encouragement on the van. You know, "Just go. It'll be O.K." When they come out angry [from treatment, I say] . . . "Just think about that. You know you're coming back tomorrow." I mean, it's that constant encouragement.

Helping the conversation stay positive

After clients have been in treatment, been to groups all day, and I'm taking them home, they usually would like to talk amongst themselves. If a client saw a building and said, "I used to buy drugs there," I would immediately tell them to bring that to the present. I would shift it to something positive, because I know that if you're trying to make a change and someone is constantly talking to you about the past, you are going to be stuck in between. I tried to talk to them about what they learned in group.

Staying aware of what's going on

[It's important to] *be aware of the attitudes of the women in the van. We had one client that got pissed off at another client, and the client was going to tell her on her own—confront her—and I said, "No, take it to group." And she did take it to group, which was the right way to do it. But you know, they can get pissed off at each other.*

Being part of the treatment team

We're in the [all] *staff meeting saying things that they have said to us . . . and their counselor is sitting there with her mouth wide open . . . "When did you hear this? That's not what she said in group. Well...she touched on it a little bit in group..." But she let it all hang out in the van . . . They want to talk to the outreach worker . . . They pretty much feel like we're on their level.*

Helping to de-stress parenting

[To make things go more smoothly in the car] *I play with the children. Once you get their attention, it seems like the mother calms down. Then the moms don't feel like they don't have the whole responsibility.*

Rules

In their interviews, all of the outreach workers reported that rules are necessary for the safety of the women and children who use transportation. Some workers reported having a list of rules taped in a conspicuous place in the van or car, or asking women to sign the list before they could ride. Other workers described some unwritten rules. One outreach worker, who kept a copy of the rules taped to the back of the bench seats in the van, described her rules this way:

We have 12 ground rules. First, no profanity, period. No hollering out of the van. They'll see a guy on the corner and want to holler out of the van. None of that. No beating on the window at people. No talking about clients when they're not in the van. Keep the focus on themselves. We don't allow them to criticize other people. If a person misses a day, its very upsetting to know that the others were talking about them. Cleaning up after themselves. Being responsible to buckle themselves in. And also, to keep an eye on the children. It's their responsibility to buckle those children up. Calling me on my pager when they're not going to show up. I don't want to go way across town to someone's house if they're not coming. It's their responsibility to call me ahead of time. No eating in the van, but I sometimes relax that a little bit, because I know sometimes they rush out of the house with a sandwich . . . but I try to get them to clean up after themselves.

Below are a number of areas in which outreach workers have found it important to have rules for the transportation process. For each of these areas, decide whether or not you think there should be a rule. If you think there should be a rule, write a rule that would be appropriate and useful to you; if you don't think there should be a rule, explain why:

1. Smoking_____

_____

2. Seat belts_____

_____

3. Car seats _____

_____

4. How long the driver will wait_____

_____

5. Van/car capacity_____

_____

6. Transporting nieces and nephews (when clients are babysitting)_____

_____

7. Who sits up front_____

_____

8. Stopping for errands on the way (for example, to buy cigarettes)_____

_____

9. Eating_____

_____

10. Other_____

_____

11. Other_____

_____

What would you do if . . . ?

The following are examples of situations that might occur in the van or car. How would you handle them?

You're in heavy traffic. You look up and two clients are arguing with one another in the back of the van.

_____

_____

It's time to drive clients home after IOP, and it's in the middle of a terrible snow-and-ice storm. You've never driven a big van in that kind of weather before, and you're scared.

_____

_____

You're scheduled to pick up a particular woman, but the last two times you went to pick her up, she wasn't home.

_____

_____

You drive up to the shelter where a client lives and honk your horn to signal for her to come out. Another woman comes out and asks you not to honk your horn in the future, but to come up to the door to ask for the woman.

_____

_____

A child gets in the car in the afternoon and talks about being very hungry. After you talk with him for a while, it becomes clear that he hasn't eaten anything all day.

_____

_____

3.6 Linkage to Support Groups

Learning Objectives

1. Discuss the importance of clients' involvement in a culture of support and recovery, and the types of support groups available.
2. Identify five types of obstacles to successful involvement in supportive cultures.
3. Discuss ways of identifying these types of obstacles in women's lives, and ways of overcoming them.
4. Discuss the benefits and challenges to outreach workers and clients when the outreach workers who are helping clients get involved in recovery activities are also in recovery.

Cultures of Support and Recovery

If the "high" of the drug were your only rival for your client's loyalty, your task would be much easier. But as you know, you have many rivals. There's the ever-seductive culture of using, full of people and places whose importance has grown large as the need to use has increased. There's the comfort of knowing that all her difficult choices are being made by the drug, the strange comfort of hopelessness and helplessness. And there's the face of death, somewhere in the background, the final option of relief from all that pain.

Putting aside the ways in which addiction has harmed your clients, how has the *culture* of addiction helped them survive emotionally, and possibly in other ways?

_____
_____
_____
_____

How does a client feel when someone asks her to give up that culture? What are her major fears?

_____
_____
_____
_____

In most cases the client's involvement in the culture of addiction has been developing for years. Seventy-five hours in treatment is not going to stop it or replace it. So one major task of outreach is to ease the client into a culture of support and recovery that will replace the culture of addiction in her life. This new culture must provide all the benefits that the old culture provided, but in new ways: pleasure that's not related to drugs or alcohol, friends and companions who live clean and responsible lives, hope for continued growth and development, awareness of a range of choices and the courage to make them, and a sense of loyalty to life and health.

The number of available self-help options varies from community to community, but here's a general list:

- Twelve-Step sobriety groups like Narcotics Anonymous, Cocaine Anonymous, and Alcoholics Anonymous
- Women for Sobriety/Women for Recovery
- Churches and church-based support groups
- Non-spiritual sobriety groups such as Rational Recovery, and Secular Organization for Sobriety
- Other Twelve-Step recovery groups like Al-Anon, Adult Children of Alcoholics, and Incest Survivors Anonymous
- Support groups for victims of domestic violence and sexual assault, grieving groups, etc.

Overcoming Obstacles to Involvement

For many women who come from painful life circumstances and severe addictive patterns, successful involvement in the recovery culture seems impossible. They face obstacles that most people never have to face. But Project SAFE outreach workers can often break down the many obstacles to involvement and address them one by one. Women who had never had success with self-help groups before are finding ways of attending meetings, staying clean, and forming life-sustaining recovery relationships.

It helps to separate the obstacles according to type, because the different types require different solutions. We'll look at five types of obstacles here: Resistance to Change, Logistical Obstacles, Philosophical Differences, Cultural Differences, and Emotional Safety Issues. Sometimes these types of obstacles will be revealed in layers: For example, after you help a client overcome her resistance to change and solve her logistical obstacles, the philosophical, cultural, or emotional safety issues will often come up.

1. **Resistance to Change:** Sometimes resistance to change, pure and simple, is enough to keep a client from trying meetings or other gatherings, or to keep her from building any momentum in her meeting attendance.

   What might be some signs that a client is experiencing resistance to change?

   _____
   _____
   _____

   What kinds of questions would you ask to find out if resistance to change is an obstacle for your client?

   _____
   _____

At many Project Safe sites, outreach workers help clients overcome their resistance to change by having recovery group speakers talk at orientation sessions, taking clients to their first few recovery meetings, introducing them to women with a history of clean time, using incentive systems (like a star on the calendar for each meeting attended), and requiring that clients get the meeting chair's signature on attendance sheets. What other ways can you think of to help clients overcome resistance to change?

_____

_____

_____

2. **Logistical Obstacles:** Many clients don't know where the meetings are, don't have transportation to recovery meetings or church services, don't have money or tokens to use public transportation, and/or don't have child care at meeting times. For many clients, issues of physical safety form difficult logistical obstacles. Simply going outside their apartment at night puts their life at risk.

   What might be some signs that a client is experiencing logistical obstacles?

   _____

   _____

   _____

   What kinds of questions would you ask to find out if logistical obstacles are keeping your clients from attending self-help sessions?

   _____

   _____

   At most sites, outreach workers give clients schedules of recovery meetings, circling those that are within walking distance. Some outreach workers give clients bus tokens or help them apply for tokens from social service agencies. Some help clients think of ways of getting child care or rides to meetings. What other ways can you think of to help clients overcome logistical obstacles?

   _____

   _____

   _____

   _____

3. **Philosophical Differences:** The non-specific form of spirituality discussed in most Twelve-Step meetings works well for many clients. Others have received images of a judging, punishing God from religion; they need to have the difference between spirituality and religion defined more clearly. Some need a non-spiritual form of recovery. Others need a spiritual format in which the word "God" isn't used to describe the source of spiritual strength. Still others do need an explicitly religious format, where specific religious terms and instructions are used. Many women are most comfortable with, and most inspired by, the culture-specific religions with which they were raised.

What might be some signs that a client is experiencing obstacles because of philosophical differences?

_____
_____
_____

What kinds of questions would you ask to find out if philosophical differences present any obstacles for your client?

_____
_____

Some Project SAFE staff address their clients' concerns about spirituality and religion by keeping those two concepts clearly separate. Others introduce their clients to non-spiritual alternatives to Twelve-Step programs, or to spiritual groups in which the word "God" isn't used. Clients who want an explicitly religious approach are encouraged to attend the churches of their choice, and some churches have formed recovery groups. What other ways can you think of to help clients overcome philosophical barriers to participation in self-help?

_____
_____
_____
_____

4. **Cultural Differences:** Culture has much to do with the general atmosphere and way of doing things in recovery meetings, church services, and other self-help formats. For example, many meetings that are predominantly African-American are very different from those that are predominantly European-American. If a client's sense of belonging is fragile to begin with, going to a recovery meeting where people act and express themselves in a way that's very different from hers and her culture's can be anything from disappointing to destructive. Beyond that, if a client has been exposed to prejudice and discrimination and has had few positive relationships with people of the dominant culture, a meeting composed of those people isn't likely to feel emotionally safe for her.

   What might be some signs that a client is experiencing obstacles because of cultural differences?

   _____
   _____
   _____

   What kinds of questions would you ask to find out if cultural differences present any obstacles for your client?

   _____
   _____

In many areas, particularly in urban areas, there are Twelve-Step meetings that are predominantly African-American or Latino. Project SAFE staff have learned where these meetings are and mark them in clients' schedule books. What other ways can you think of to help clients overcome cultural differences?

_____
_____
_____
_____

5. **Emotional Safety Issues:** For many clients, recovery meetings and church services don't feel emotionally safe. They have overwhelming fears and feelings of being judged and being different from—and inferior to—others. For many women, meetings that also include men can feel unsafe because it's hard for them to speak honestly about personal issues in the presence of men. For women who have a hard time resisting involvement with men or saying "no" to persistent or predatory men, co-ed meetings might be sources of danger. The often high levels of intimate sharing at these meetings can set the stage for sexual and/or emotional involvement—involvement that puts recovery at high risk.

   Aside from sexual issues, other areas of danger also exist. For example, in some individual Alcoholics Anonymous meetings, clients might meet members who use shaming techniques to try to motivate newcomers (like telling people with depression that they're "on the pity pot") and interpret the AA literature in ways that discount the clients' experience. Even clients who are in tune with the general Alcoholics Anonymous philosophy and meeting format often find these specific meetings much more harmful than helpful. And finally, if clients believe that you're encouraging them to have ongoing involvement with self-help groups so that they won't need your help any more, this can trigger fears of abandonment.
   What might be some signs that issues of emotional safety are presenting obstacles for a client?

   _____
   _____
   _____

   What kinds of questions would you ask to find out if issues of emotional safety present any obstacles for your client?

   _____
   _____

   Going to the first few meetings with clients, introducing them to people who won't violate their emotional safety, and preparing them for meetings by bringing in recovery group speakers can help some clients deal with the fear of being judged and being different. Women with dual disorders will need therapy outside of recovery group meetings, and will need to take any required medication consistently, or they'll have a hard time learning to attend recovery group meetings and build support networks. To

side-step the gender issue, many outreach workers steer clients toward all-women's meetings. Some communities have meetings of African-American women. It's also a good idea to know what a specific meeting is like—and what the people who usually attend it are like—before referring clients to it.

Your clients' involvement with self-help groups should begin while you're still very much involved in their lives. These two forms of support must be carried on at the same time. If you get a sense that a client feels you're planning to abandon her, you can reassure her that you'll still be there for her even after she builds a full life in recovery. What other ways can you think of to help clients overcome emotional safety issues that are blocking their involvement in self-help groups?

_____
_____
_____
_____

As the obstacles have been removed, many clients have found that they no longer feel "sentenced" to recovery activities. The people they meet, and the social networks they form, more than make up for the loss of their old using friends. The principles and rituals of their support systems—and the long, slow process of personal growth—serve to heal the pain that the drugs both masked and aggravated.

Considerations for Outreach Workers in Recovery

What are some of the benefits of having outreach workers who are also recovering from addiction introduce clients to self-help groups?

_____
_____
_____

What are some of the complications that might come up?

_____
_____
_____
_____

How might these complications affect the client?

_____
_____
_____
_____

How might these complications affect the outreach worker?

_____
_____

If you're in recovery for addiction, you might sometimes wonder how much information about your personal history to give your clients. Different sites and supervisors have different guidelines on this, and different outreach workers are more or less comfortable talking about their experiences. If you're in recovery, and if you have guidelines that you've set or received from your supervisor or your agency, what are those guidelines?

Some of the outreach workers who were interviewed talked about the importance of setting clear boundaries between the client's and the outreach worker's recovery activities, to give each one privacy. This can be difficult if both live in the same neighborhood, go to the same meetings, and socialize with the same people. The outreach worker whose clients are present at her meetings may have a hard time separating her work and personal lives. And the client whose outreach worker shows up regularly at her meetings may have a hard time learning to relate to her as just another group member. What are your thoughts on appropriate boundaries for clients and outreach workers in recovery groups?

A number of clients expressed gratitude for the message of hope that outreach workers in recovery can bring. One client described that message as she heard it from her outreach worker's words and actions: "I been there, you know? I know how it is. I know the loneliness and the anger and the denial and everything like that. I know that. I been there, but it's a light at that end of the tunnel. You will see that light."

Resources

For an in-depth look into the addiction and recovery cultures, read White, W.L. (1990). *The Culture of Addiction, The Culture of Recovery.* Bloomington, IL: Lighthouse Institute.

3.7 Parenting Support

Learning Objectives

1. Define "parenting support" and give examples of this process.
2. Describe the outreach worker's role in providing parenting support to clients.
3. Name three different ways an outreach worker can provide parenting support.

Definition

In Project SAFE, "parenting support" has many facets. It includes:

- providing emotional support to the addicted woman in her mothering role;
- serving as a parental role model;
- providing in-home consultation to women in treatment who are taking parenting classes; and
- working to enhance the relationship between the mother and her children.

The intense stress of the mother's role makes this kind of support essential. Being a mother is especially difficult for women who have substance-abuse problems; who have no partners or other natural support systems; and who often have no foundation for, or experience of, effective parenting. Many of these women have had poor parental role models or have lost their parents through death or separation.

Background and Examples

Most agencies have parent-training programs for women in treatment. The outreach worker has a unique opportunity to help clients both understand and apply the knowledge and skills they learn through the parent-training curriculum. Project SAFE staff have found that these programs must include both personal living skills and basic caretaking skills. This may include training in housekeeping, cooking, grooming, dressing, and social communication skills—everything from how to pack a diaper bag and prepare bottles to the importance of immunizations and realistic expectations for child development.

The following are examples of different kinds of help:

Providing emotional support specific to parenting

You know. . . if it was a situation about my kids that had me kind of down, she would just talk to me, tell me to keep my head up, you know, things would work out. (Client quote)

Fostering the mother/child relationship

[While I was in treatment] *she made sure that the kids came, and made sure that my visits were increased—stuff like that.* (Client quote)

I can think of an incident where the mother had three children. The two older children were very active, but the youngest child was just blank. And [the outreach worker] *brought it to my attention and we met with the mother, and after talking with her we found out that she didn't bond with the child. She didn't want the child, so we were able to refer her to counseling. After about four months, her bonding began to take place and you could see a difference in baby and mother.*

Helping with routine parenting activities

I've had to go into their homes and help them get their children ready.

If we go into a house that's untidy, we give the mom suggestions as far as how to help the home get better. How to go grocery shopping. We help them make a grocery list. Tell them to clean up the house at night before the kids go to bed. Then in the morning, all you have to do is make up beds. So we don't put them down because their homes aren't clean. We give them suggestions on how to make it better.

Helping with medical issues

A lot of clients haven't taken the kids to the doctor, so we make the appointment. We call like we're the mom, make that appointment for them, tell them when it is and see if they can get there on their own, and if they can't, we take them. . .Once we start helping them, they find the means to do it on their own. But, initially a lot of the footwork as far as getting the child into school or to the doctor, we have to do it, because the client won't do it.

The outreach worker said something was wrong with the child. The mother said she took her to the clinic and got medication. The mother was administering the medication. We had her bring the medication, but the child didn't look any better after two days. We were able to take the child directly to the hospital with the mother. The child was dehydrated and losing fluids. So they said that had the mother not been encouraged to bring the child in, the child probably would not have made it. That was one instance, had the outreach worker not been there. . .

Providing guidance

[The outreach worker] *is like a surrogate Mom or extended family member. . .someone who can steer them in the right direction in terms of what to do with their children—things they are not familiar with.*

A lot of these people don't even know that you can go to the zoo free. Pack a lunch—peanut butter and jelly and a little snack here and go to the zoo and just have a ball. They don't know these things. A lot of them think that "everything I do with my kids is going to cost me money and all I get is this much money each month."

We give each other suggestions, and I think toward the end they finally see that this child was just like you—you weren't cooking for this child, you weren't feeding the child. The child had no rules they had to follow. Now all of a sudden you want to cook, clean up, give them rules. You have to let the child know what you're going through, the transition you're going through, so you can go through it together. . . there's no book that comes

with children. You have to let them know: "Mommy was doing some things that weren't good, and now I am trying to get help, and now you have to help me."

Teaching how to cope with the stress of parenting, or helping to reduce that stress

Well, we take them on trips. We have a couple of trips planned this month. To the zoo and a cookout with the moms and the kids. Just. . . trying to bring them together and help them to understand the feelings that they are going through when they get stressed, and how to deal with it instead of taking it out with their kids. [We tell the mothers,] *"The catch is that we're taking all of your kids. If you've got four kids, you're responsible for four kids. We're going to be there supervising, and if you get overwhelmed we'll step in. But we want you to remember what it's like for Joey to throw a tantrum, Suzy to get tired and can't walk and you have to carry her, Becky's pulling on Suzy's hair—all at the same time. We want you to remember that! So we are taking them all with us.*"

We talk about frustration and anger and sometimes how we have to stop and count to ten or say a prayer, and then deal with the children—my son is three years old so I definitely can relate to what they're talking about.

A lot of the time they're embarrassed because they don't really know how to parent the children and they're going to naturally act out. And they want them to be on their perfect behavior and that's just not going to happen. So I personally try to connect with [the kids] *right away. Kids love that. And it seems to calm the parent down a lot.*

Providing material help

Like if the kids need things like—you notice one kid doesn't have on any socks. When we go shopping or go places, we pick up stuff and give it to them. If we go to Catholic Charities—we just gave one woman a whole big sack of baby clothes that we got from a friend's aunt. So we help them out in ways like that. We find toys to keep the kids busy so they can have a little peace.

I carry little extra snacks in the car, because a lot of the women don't feed their children in the morning.

Reinforcing lessons from parenting class

[The child] *got Waterford crystal glasses and—I don't know—he did something with them. It was a no-no. She said, "Before I started coming to parenting classes, I would've spanked him. He knows he doesn't do that!"*

She told me that she learned so much from the parenting classes. And I thought that was good, because she said that was the only way she knew to discipline. Do what I tell you to do. . .and after the third time, then I get my belt. And she says, now, "I'm learning other ways." And then we talked about different instances—she told me things she did, "time-out" and all that.

Describe examples from your own experience of how you've helped in the following areas, and add other categories of parenting support that you've provided:

1. Providing emotional support_____

_____

2. Fostering the mother/child relationship_____

_____

3. Helping with routine parenting activities_____

_____

4. Helping with medical issues_____

_____

5. Providing guidance_____

_____

6. Teaching how to cope or helping with the stress of parenting_____

_____

7. Providing material help_____

_____

8. Reinforcing lessons from parenting classes_____

_____

9. Other_____

_____

10. Other_____

_____

If you don't teach the parenting class at your agency, ask your supervisor if you can sit in on some of the classes or read through the curriculum. Ask the instructor what skills she'd like you to reinforce on home visits.

3.8 Crisis Management

Learning Objectives

1. Define "crisis."
2. Examine typical crisis situations and talk about how they might be addressed.

Definition of "Crisis"

A crisis is a state of being caused by unexpected changes in the environment or the person that, if it's not managed in a timely and appropriate way, can be harmful to the person in crisis or to others. An outreach worker's job includes being available to the client and her children in times of crisis, to provide the support needed to manage the crisis, or to link her with other appropriate sources of support.

Examples of Crises

Examples of crises with this population are homelessness, acute health problems of the mother or child, or hints or threats of suicide. One outreach worker described the crisis-intervention role this way:

> *What do we got? About eight or nine ladies now? I can say everybody's different. And where this fire may be little, this fire may be big, if you don't catch this one right now, it's going to be super big! It's always something. There's never a dull moment with our ladies. No, they keep you going.*

Handling Crises

As one outreach supervisor told us, it's important for an outreach worker to be able to know what level of crisis he or she can handle. It's equally important to know which crises must be handled immediately, and when it's necessary to bring the client back to talk to a therapist. In the space below, write what you've learned about handling crises from your agency, and any questions you have about crises or methods of handling them.

_____

_____

_____

_____

What would you do if. . .?

Several case managers talked about homelessness as the most serious crisis faced by the women with whom they work. The following are real-life examples of crisis situations faced by outreach workers. After reading each case, list the steps you'd take in dealing with the crisis.

One of the clients relapsed and I came over to pick her up. Her mother kicked her and her babies out onto the street. And they were just standing there with a suitcase, waiting on me. It was cold outside and she was crying one minute and okay the next.

_____

_____

_____

There was a time where one of the females was very, very intoxicated and she had a violent history and we were quite aware of that—but she had been doing really well. And she went and stayed in her apartment and she wasn't coming in to her groups. So I thought, "Well, I better get over there and see what's going on," because she missed the group that day. Well, I wasn't able to get over there until later in the afternoon and, of course, she was very intoxicated and she was very upset with her significant other and she was going around taking knifes and forks and going around. . .and it's like. . .she's using very foul language and saying that I'm going to do this and do this to that.

_____

_____

_____

A client is talking about suicide.

_____

_____

_____

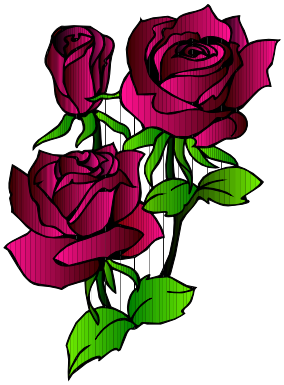
It becomes evident that the man she lives with is abusing her.

_____

_____

_____

_____



Section 4.0
Issues in Service Delivery

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4.1 Providing Outreach Services to Women of Color

Learning Objectives

1. Become more aware of your own cultural attitudes where women of color are concerned, and how those attitudes might affect your work with clients.
2. Discuss some of the issues that many African-American women and Latinas bring into treatment.
3. Discuss some of the strengths and other resources that are prevalent in African-American and Latino cultures, families, and communities.

Why Address These Needs Separately?

In most cases, a woman's life is affected profoundly by the culture into which she was born. Much of how she thinks and feels about herself, many of the circumstances that surround her, and many of the decisions that shape her life are influenced by the color of her skin, the language she speaks, the customs she learns, and the whole web of attitudes and prejudices that have been held up like a mirror all her life.

Many women who "fail" treatment do so because treatment programs fail to understand their cultural realities or to meet their cultural needs. That's not what it says on their charts, of course. They never told anybody this was why they dropped out of treatment. In many cases, women wouldn't know how to begin to explain the problem, even if they felt safe saying anything. In most cases, they've been taught to blame themselves instead.

More than most other treatment programs, Project SAFE has been designed with full knowledge of, and respect for, the specific needs and realities of women of color. Unfortunately, that's not enough. Every staff member needs a personal awareness and understanding of everything that a client's culture means to the client, and to the staff member. Every program must use culturally appropriate resources and language. And everyone who works with a client must be fully aware of the strengths and resources within her culture that can help her succeed in recovery.

Looking at Yourself

In working with women of another culture—or even of our own culture—the most important foundation is an honest appraisal of your own cultural attitudes and beliefs. As you answer the following questions, use the name of the culture to which the women with whom you work belong. If you work with both African-American and Latina women, do the exercise twice. Complete the following statements, writing whatever comes to mind (don't try to write just what you think people want you to write). Answer these questions even if you are of the same culture.

African-Americans/Latinos are:_____

_____

_____

_____

African-American women/Latinas are:_____

_____

_____

_____

Chemically dependent African-American women/Latinas are:_____

_____

_____

_____

How do you think your African-American/Latina clients see themselves?_____

_____

_____

_____

How do you think those self-perceptions affect their success in treatment?_____

_____

_____

_____

When you were answering those questions, how did you feel?_____

_____

_____

Our most powerful feelings, attitudes, and beliefs about our own culture and other cultures come from our life experiences. We need to be fully aware of those experiences and their impact on us. Then we can see where our feelings, attitudes, and beliefs might be getting in the way of our effectiveness in our work, and take steps to keep that from happening.

Please take a moment to think about what you learned about African/American and/or Latino cultures, women, and men in various areas of your life and development. You might have learned these things through what you saw, what you were told, what you experienced, etc. What did you learn about African-Americans/Latinos:

...in your family of origin?_____

_____

_____

_____

...in your experiences with those communities (in school, play, dating, etc.)?_____

_____

_____

_____

...in your professional life?_____

_____

_____

_____

...from the environment (the media, etc.)?_____

_____

_____

_____

The Effects of Cultural Attitudes on Clients

As you read in the module on "Realistic Expectations"—and as you've learned from your clients—much of the success of treatment rests on the client's ability to believe that there's hope for her. If the mirror that your attitudes hold up to your client shows a person with inner strength and beauty, she's more likely to find that strength and use it to defend her inner beauty. But if the mirror you hold is distorted by negative cultural images, she'll see those images. At best, they'll damage her ability to trust you. At worst, they'll damage her ability to believe in herself.

In his research on cultural issues, Peter Bell has identified some of the effects of cultural attitudes on counseling styles. These concepts can also be applied to outreach styles, and to agency practices as a whole. This information is important for anyone who works in a helping role. Bell gives the example of a European-American therapist working with an African-American client, but it could be a therapist or outreach worker of any culture, working with a client of any culture. Here are the categories of cultural attitude that Bell identifies:

- *The Overtly Racist Therapist:* This is the therapist who says and/or does things that are entirely inappropriate, because of his or her own prejudice. The client may react by shutting down emotionally and, in many cases, leaving treatment. No effective treatment

will take place in the presence of this dynamic.

What are some overtly racist things that a therapist might say or do?

_____

_____

_____

At any time in your life could you have been described as "overtly racist" toward any culture? Please explain.

_____

_____

- *The Covertly Racist Therapist:* This therapist may or may not be aware of his or her own prejudices, and usually communicates them in indirect ways: hidden messages, body language, tones of voice, facial expressions, etc. The client sees and hears these messages loud and clear. Even if she weren't so vulnerable she couldn't confront them, because they're not stated. The client may feel confused and angry and shut down emotionally. Sometimes the client will remain in the relationship, but still carry the burden of all the unexpressed anger and confusion. As with the overtly racist therapist, no effective treatment is taking place.

  What are some covertly racist things that a therapist might say or do?

_____

_____

_____

At any time in your life could you have been described as "covertly racist" toward any culture? Please explain.

_____

_____

- *The Culturally Ignorant Therapist:* This therapist is simply unschooled about the client's culture, through lack of exposure and education. He or she doesn't understand the client's culture and doesn't know how to interact effectively with the client. This therapist's mistake is the failure to admit that he or she lacks the necessary knowledge, along with the failure to get help for this lack. As a result, the client's treatment is not appropriate. The client often realizes that the therapist doesn't know what he or she is doing, which makes it more difficult to build the kind of trust and safety necessary for a successful therapeutic relationship. In some cases the client may take it upon herself to educate the therapist, a process that might place an unfair burden on the client.

  On a scale of one to ten, where would you rate your cultural experience of, knowledge of, and comfort with these elements of your client's culture:

African-American	*Latino*	*Another Culture*

Language and way of speaking	_____	_____	_____
Community	_____	_____	_____
Family customs and structure:	_____	_____	_____
Sense of humor	_____	_____	_____
Cultural self-image	_____	_____	_____
Social structure	_____	_____	_____
Cultural values	_____	_____	_____
Definition of respect	_____	_____	_____
Cultural insecurities	_____	_____	_____
Cultural strengths	_____	_____	_____
Cultural religious influences	_____	_____	_____
Race or culture overall	_____	_____	_____

- *The Color-Blind Therapist:* This is the therapist who believes that all women have the same issues regardless of culture, and doesn't take into account the strengths and needs problems specific to the client's culture. Handed a "canned" treatment program, the client often feels left out, unrecognized, invisible. Some of her deepest, most important issues remain unaddressed.

  What are some color-blind things that a therapist might say or do? _____

  _____

  _____

  At any time in your life could you have been described as "color blind"? Please explain.

  _____

  _____

- *The Culturally Liberated Therapist:* This therapist is fully aware of his or her own attitudes toward all cultures, having assessed those attitudes not once, but on an ongoing basis. This therapist has done the appropriate research, gathered information, and gained education in working with the specific client populations. The client feels understood and respected, trusts the therapist's competence, and knows that she can't use her cultural experiences as an excuse for not working on getting well.

  How would you assess your present level of progress toward being culturally liberated?

  _____

  _____

  _____

  _____

What steps might you take to become more culturally liberated, especially in your work?

_____

_____

_____

_____

Issues Faced by Many Women of Color

The types of emotional wounds that women of color sustain in childhood and adulthood are not unknown to other women, or to treatment clients in general. But it's safe to say that certain issues tend to arise more often and spring from deeper places in the lives of African-American women and Latinas. It helps to look at these issues and think about how they affect your clients. They're divided here according to the types of relationships in which they occur.

- *Relationships with service providers:* Many women of color have been the objects of prejudice and discrimination by service providers, from childhood through the present. This has damaged their ability to trust helping professionals, and their fear of the violation of any trust that might develop. If the service provider is of the same culture or race, this might or might not help. The service provider might be seen as having "sold out."

  When you begin to work with a client, try to learn or imagine how many helping professionals have worked with her in the past, and what her experience with them might have been. Especially if she comes from a disempowered culture, her fear of losing (or never regaining) custody of her children might be so intense that it gets in the way of her ability to build an honest relationship with you.

  In your clients' actions and attitudes, what signs can you see of negative experiences with service providers?_____

  _____

  _____

- *Relationships with the immediate family:* In many African-American and Latino families, there are strong spoken and unspoken rules against discussing the family's business with outsiders. This can be a significant challenge for the client who has unresolved family issues that can be healed only if she betrays this deeply rooted family value. You need to explore methods of respecting this value while you help her find a way to balance it with her recovery needs. She might also fear loss of power within the family if she enters treatment and begins to change.

  How do you see these and other family-related issues in your clients' lives?

  _____

  _____

  _____

- *Mother-daughter relationships:* Especially in African-American families, the bond between mother and daughter is very important. When that bond is disturbed—in the relationship between the client and her children, or in her relationship with her own mother—there is great pain and fear. These kinds of issues must be respected and addressed in culturally appropriate ways.

  What are some of the problems that arise in your clients' relationships with their mothers, and how does this seem to affect their well-being?_____

  _____

  _____

- *Relationships with the extended family:* In both African-American and Latino cultures, the extended family is vitally important. Many women feel a deepened sense of shame, for fear that their extended family will know that they are in trouble. But in many cases involving the extended family effectively can be the key to the client's successful recovery. Outreach can and must play a key role in these efforts.

  Describe your clients' involvement with their extended family. _____

  _____

  _____

- *Relationships with men:* In some African-American communities, historical social and economic forces have had a major impact on the roles of men. Out of necessity, women have assumed responsibility, but in some cases they have been blamed for the imbalance of economic advantage. Some men have tried to compensate for their loss of economic power by becoming controlling or abusive toward the women in their lives. Some African-American women and men struggle with issues of mutual anger, lack of respect, mistrust, and confusion about their relationships.

  In many Latino communities, men still hold quite a bit of power—economic, physical, sexual, and emotional—over women. More and more Latinas have been claiming equal power and rights, but not without quite a bit of resistance from the men. When you work with women, it's important to understand the balance of power in their relationships with men, and all the cultural and economic factors that have contributed to it.

  How would you describe your clients' relationships with men?_____

  _____

  _____

  What role does power play in those relationships?_____

  _____

  _____

- *Relationships with religion:* In many African-American and Latino communities, the church is a great source of spiritual and cultural strength. The tendency in treatment to separate spirituality and religion may not work with clients whose spirituality is so closely entwined with the religion in which they were raised. It's important to be aware of these factors, and to respect each client's personal definition of spirituality. It's

equally important to consider the churches of your clients' cultures as possible sources of help and support.

Describe one client's relationship with the faith community in which she was raised.

_____

_____

_____

- *Relationships with themselves:* Many clients who have been victimized by prejudice and discrimination have learned to believe the lies that they were told about themselves. Many people carry the shame of their culture's and/or their gender's entire history. They might not mention these beliefs, or even be aware of them, but the shame can sabotage your best efforts to help. And how are they to find their identity if their history or cultural traditions have been objects of shame, or have been dismissed as unimportant? It's important for all helping professionals who work with women of color to help and encourage them to: 1) experience their cultural traditions and celebrations; 2) learn the history of their cultures, families, and communities; and 3) develop healthy and effective strategies for coping with racism.

  How do issues of self-esteem affect your African-American and Latina clients' lives?

  _____

  _____

  _____

  _____

- *Relationships of women within the Latino community:* Many women of color struggle with their relationship to the dominant American culture. Among Latinas in particular, there are various different degrees of aculturation. Women who have recently arrived from Mexico, for example, may be much less assertive and have a lesser potential for independence compared to Mexican-American women who were born in the U.S., or who have been in this country for many years.

Strengths and Resources in African-American and Latino Cultures

It will take much more than a page in this manual to acquaint you with all of the strengths, resources, and resiliencies available in your clients' cultures of origin. If you're already familiar with these assets, you can play an important role in your clients' re-education process. If you're not familiar enough, you can learn a step ahead of your clients. What is important is that you learn, and that you affirm the strength and beauty that they can find within themselves and within their cultural traditions.

The cultural stereotypes about African-American and Latino communities, families, and women can be powerful agents in destroying hope and the will to survive. Your clients need an equally powerful antidote in order to succeed in recovery. But it can't just be a denial of the stereotypes.

Instead, it must be a search within the cultures themselves, to find the strengths that are sometimes hidden by circumstance, but are so apparent to anyone willing to see them.

In many ways it means building a vision of a healthy African-American or Latino family. There are many examples out there waiting for recognition. The following are some elements of healthy families, from the work of Robert Hill. Although Hill was writing specifically about healthy African-American families, many of these strengths can be found in healthy Latino families as well.

- *Strong bonds and shared identity:* African-American and Latino families are known for the strength of their connections, within the immediate family and in the much larger extended family. Used for recovery, this deep love and loyalty can be powerful resources.
- *High achievement orientation:* There are many healthy African-American and Latino families who wouldn't even think of letting their children drop out of school or not finish college or trade school. Most families take great pride in their members' achievements, and many have much to be proud of.
- *Flexibility in family roles:* This is a particularly strong asset in African-American families, where flexibility has often been necessary to survival. It's important to avoid putting too much responsibility on older children, but the family's flexibility should still be recognized as an important strength.
- *Strong religious orientation:* Much strength has come from families' active involvement in religious and spiritual life. This can be put to the service of recovery.
- *Creativity:* Both African-American and Latino cultures are full of art, music, poetry, innovation, and life. The very struggles that cause so much pain give rise to beauty.
- *Communal values:* In contrast with the dominant culture's focus on individualism, most African-American and Latino communities have a strong sense of collective responsibility. These are well reflected in the seven principles of Kwanzaa (the Nguzo Saba), taken from the work of Dr. Maulana Karenga. The seven principles are Umoja (unity), Kujichagulia (self-determination), Ujima (collective work and responsibility), Ujamaa (cooperative economics), Nia (purpose), Kuumba (creativity), and Imani (faith). The celebration of Kwanzaa was developed as a celebration of African-American values and principles, but these principles can give strength to other clients, families, and communities and communities as well. Communal values can be life saving for one whose very survival depends on going beyond her own individual power and combining her strength with the strength of others.

How do you see these and other strengths reflected in your clients' cultures of origin?

_____

_____

_____

How can you use words to tell clients about your belief in, and appreciation of, these strengths?

_____

_____

_____

How can you convey your belief in these strengths without using words?

_____

_____

_____

Reading Resources

Bell, P., with Donna Peterson (1992). *Cultural Pain and African-Americans: Unspoken Issues in Early Recovery.* Center City, MN: Hazelden.

Hill, R. (1971). *The Strengths of Black Families.* New York: Emerson Hall.

Karenga, M. (1988). *The African-American Holiday of Kwanzaa: A Celebration of Family, Community, and Culture.* Los Angeles, CA: University of Sankore Press.

4.2 Empowering Vs. Enabling

Learning Objectives

1. Discuss the two concepts “empowerment” and “enabling” and the differences between them.

2. Discuss some common changes in the level of client need during involvement in Project SAFE, and how those changes affect the outreach worker’s empowerment role.

3. Identify instances of empowerment, enabling, and abandonment.

Empowerment and Enabling

As you’ve heard and probably experienced, “Empowerment” is a process of learning how to find the strength, courage, and other resources needed to meet life’s challenges. A client’s empowerment process often begins when she meets a woman who can give her the nurturing she needs without trying to use or manipulate her—a woman who also stands as an example of strength, courage, and other resources in action. In empowerment, the main message is, “People like us can survive and succeed.”

“Enabling” often starts out looking like empowerment, because they both seek to nurture the client and build safety. But enabling is in many ways the opposite of empowerment. It ignores the client’s own resources and responsibilities, and seeks to “do for” the client long after she’s ready to start testing her wings. The message of enabling is: “You won’t survive unless I do these things for you.”

Project SAFE clients, with their deep wounds and extreme levels of need, make it hard to tell the difference between empowerment and enabling. The outreach worker's role is by nature a nurturing one. It requires Tough Love—sometimes heavy on the Love and light on the Tough. Outreach workers with a background in traditional treatment have sometimes had to try things they once believed they weren’t supposed to do—like show up on a client’s doorstep for weeks in a row before she even decided to enter treatment—and found that those things meant the difference between life and death for the client.

Think about the process of empowerment that you’ve gone through in your own life. What are some of the things that others have done—or not done—that have left you feeling more powerful, more capable, more sure of your ability to succeed?

_____

_____

_____

_____

Based on those experiences, how would you personally define “empowerment”?

Now think about things that others have done—almost always with good intentions—that have left you feeling a little more dependent on them, a little less capable of doing it for yourself. What are some of those things?

Based on those experiences, how would you personally define “enabling”?

The Helper's Needs

One difference between empowerment and enabling has to do with the needs of the person who's helping. It's in our basic nature as human beings to need to help others (although not everyone is in touch with that part of our nature). We get good feelings from giving, and from seeing the people we're helping get better and succeed. When we take part in the healing of another human being, that healing process heals something in us, too. This is the “selfish” side of empowerment. We get a spiritual power from it that leaves us stronger and more joyful.

Think of a time when you've done something that was truly empowering for a client or another person—left her stronger, more independent, and more confident. What thoughts did you have just before taking that action?

What feelings did you have just before taking that action?

How did you feel after that incident?

Like empowerment, enabling also has its selfish side. But in enabling, the dominant need is for control. We don't trust the person to do the things that she needs to do for herself, so we do them for her. We're afraid she'll do them wrong, she won't do them quickly enough, she'll reflect badly on us, etc. We might even be afraid of her pain, and all the uncomfortable feelings it raises in us.

The power we get from enabling is not spiritual power. It's a kind of psychological power that may give us more control, but it doesn't leave us stronger. It actually leaves us weaker, because it has fed our fears and insecurities. And we can do all of this with absolutely good intentions, and no desire to enable or make anyone weaker. Alcohol and drugs aren't the only things that are "cunning, baffling, and powerful."

Think of a time when you've done something that turned out to be enabling—left someone a little more dependent and a little less sure of her strengths. What thoughts did you have just before taking that action?

_____
_____
_____

What feelings did you have just before taking that action?

_____
_____

How did you feel after that incident?

_____
_____
_____

In the future, what kinds of thoughts and feelings might tell you you're about to do something enabling?

_____
_____
_____

As one outreach worker said, you can tell when you've crossed the line from empowerment to enabling when a client stops saying "I tried to do . . ." and starts saying "I need you to do . . ." all the time. "I tried" tells you that you've been encouraging her to find her own resources. "I need" tells you that you've been spoon-feeding her as if she were a child.

The Importance of Timing

As if making this distinction weren't hard enough, there's the question of timing. At different

times in a client's progress, the same action on your part could be empowering or enabling. Think of a tiny baby in your arms. Her neck muscles aren't strong enough to hold her head up, so you have to support her head with your hands. At a certain point in her development you need to let go so she can practice using those neck muscles and strengthening them.

In the early days, a resistant client will swear she needs nothing from you. Then as she gets involved in the program and starts to trust you, her intense dependency needs will show up. Her fears are enormous. Her skills are unformed. She truly needs you to help her with things that most people take for granted. More than that, she desperately needs to feel safe needing someone, and to have that person respond to her needs and not use her or punish her. She never got that as a child. Letting her need you is part of the re-parenting process that will help her grow up. It is an opportunity for you to fill an unmet need from the clients childhood so that she can progress in recovery.

Describe a client in this dependency stage of recovery.

_____
_____
_____

How do you feel when you work with this client?

_____
_____

After a time, you need to back off a little and let her find ways of doing things for herself. Finding this point in the process can be tricky, because she may still have strong fears and still want to rest in that safe dependency. Or she may feel like she's ready to do it for herself, but still needs you right there in case she falls. She'll be scared at first, but after a few successes, she'll realize that she can handle it. Then you'll take on the role of a proud parent, applauding her success.

There's no sure formula that can tell you when to start letting go. It depends on many things: her circumstances, her motivation, the depth of her wounds, her additional disorders, etc. Sometimes your logic will tell you when to let go, but more often you might have to listen to your gut feelings, or even have a talk with your supervisor.

Describe this gentle "backing off" process with a client.

_____
_____
_____

How did you know when it was time to start letting go (and/or putting the supports back in place)?

_____
_____

How did this process feel to you?

And finally, it's important that this process of letting go not feel like abandonment to the client. Most clients' abandonment issues are so deeply rooted that no amount of time in recovery will completely erase them. A client may graduate from Project SAFE, and from your intensive involvement in her life, but she doesn't graduate from her relationship with you.

Many outreach workers say that their clients still call them from time to time after graduation, when they need help or when they have major successes to report. This ongoing involvement in their lives gives clients more and more evidence that they matter to you and that they're not alone.

Telling the Difference

Faith is on a waiting list to enter treatment at Project SAFE, and you're her outreach worker. This is your third home visit. Her apartment is a mess, with dirty dishes piled up in the sink and roaches crawling everywhere. She's been depressed, and when you showed up at 11:00 she was still in bed and you could tell she's been crying. Her bills haven't been paid, her electricity has been shut off, and there's an eviction notice on her door. She asks you if you could get someone to pay the bills for her.

What might be an enabling response?

What might be an empowering response?

What might be an abandoning response?

Leisha is almost through her treatment, and she's been making progress and getting stronger. You're driving her home, and she's the last one you're going to drop off. She's talking about all the things she has to do—bills to pay, appointments with doctors and social service personnel, etc.—and how hard it is to get everywhere on public transportation with no money or tokens.

You get the feeling that she wants you to offer to take her to these places, but she hasn't asked you.

What might be an enabling response?

_____
_____
_____

What might be an empowering response?

_____
_____
_____

What might be an abandoning response?

_____
_____
_____

4.3 Minimizing Manipulation

Learning Objectives

1. Discuss the concept of manipulation as a survival skill.
2. Identify some common types of manipulation that clients use, and discuss ways of responding to those types of manipulation.
3. Discuss the development of healthy survival skills as the most effective antidote to manipulation.

Manipulation as a Survival Skill

Much has been said in this manual about the painful, humiliating, and sometimes tragic circumstances of clients' early lives and their years of using. These experiences have left clients with a number of deeply rooted symptoms, ranging from substance abuse to denial to fierce emotional outbursts. All of these symptoms had the same origin: They started out as ways of surviving, and they used to work very well.

For most clients, another critical early survival skill was manipulation. Simply put, manipulation is whatever we do to get what we want (or get away from what we don't want) when we can't get it in direct and honest ways. Manipulation is the all-purpose tool of the powerless. It is absolutely necessary for children's survival in abusive and neglectful situations. It is absolutely necessary for survival on the street, and in the using culture. Sometimes manipulation is a matter of conscious choice, and sometimes it's not. But it always feels completely necessary to the person who's using it. This is usually true long after the person has left the situations where manipulation was necessary for survival.

Think of a current client you know fairly well. Think of her childhood, her using years, and all the relationships she's told you about. What were some of the circumstances that made her powerless?

_____
_____
_____
_____

What kinds of manipulation would she have had to use in order to survive, physically and emotionally, in those environments?

_____
_____
_____
_____

What kinds of manipulation has she used (or tried to use) with you and other Project SAFE staff?

How would she feel if she woke up one day and she couldn't use any of those manipulation skills?

Would she simply get honest all of a sudden, or would she reach for another survival skill learned in her early years or her using years? What survival skill would she probably use?

Even after skills like manipulation are no longer necessary for physical survival, and even after they stop working the way they used to, the client still has an emotional need to use those skills. Many psychologists believe that, when a client's main survival skill is taken away, she'll reach for a more primitive survival skill. In the case of most Project SAFE clients, the arsenal of survival skills contains some very dangerous weapons, including substance abuse and violence.

That's all well and good, but what about the outreach worker who has to listen to all of the manipulation? What about all the lies and excuses and guilt trips and mind games? Don't those things get in the way of recovery? Absolutely. At its best, Project SAFE is a world in which manipulation doesn't work. But it also needs to be a place where manipulation stops being necessary, because she's finally safe. She'll test that world again and again, and it needs to keep coming up safe.

What are some ways in which Project SAFE is emotionally safe for clients?

What else could be done to increase clients' emotional safety?

The Many Faces of Manipulation

As staff, it's your job to keep from falling for the manipulation, and at the same time show by your example what an honest, non-manipulative person can accomplish. You become the structure in which the client can re-form her character and her ways of communicating. Here are a few forms of manipulation commonly used by clients:

- **Triangulation:** Triangulation is a handy word for those cases in which one person goes behind another's back and talks to a third person in order to get something or to discredit the other. As one outreach worker said, ". . .like kids play parents—mom against dad—they'll play outreach worker against case manager."

  Sylvia didn't like the answer that her outreach worker gave her when she asked for special permission that was up to the outreach worker to approve or deny, so she went to her case manager and asked her to overturn the outreach worker's decision. She told the case manager that the outreach worker had personal reasons for making the decision that she made, and that the outreach worker had said some negative things about the case manager in the past.

  How should the case manager respond to Sylvia's request? How should both staff members handle the situation?

  _____
  _____
  _____

- **Limit-Testing:** This can be anything from taking the seat belt off in the van, to asking for special favors that she knows are against the rules, to yelling and cussing in situations where it's not okay to yell and cuss.

  What are some gentle but firm ways of setting and defending limits?

  _____
  _____
  _____

  How do your methods change when it's the 20th time she's tested this particular limit—the 20th time today?

  _____
  _____
  _____

- **Lies and Excuses:** Outreach workers report high levels of imagination among many of their clients. Some lies and excuses are transparent; others need to be checked out. As one outreach worker said, "Don't even get into the excuses."

  What do you do or say when a client is telling you something important that you know isn't true?

  _____
  _____
  _____

What do you do or say if you're not sure whether or not it's true?

_____
_____
_____

What might make this client feel safe enough to start telling the truth?

_____
_____
_____

- What's another form of manipulation that clients often use?

_____
_____
_____

What's your best response to this kind of manipulation?

_____
_____
_____

Saving Face

One factor that complicates the search for the appropriate response to manipulation is the importance of not shaming the client. She needs to save face, even though at the moment it's a false face. People who rely on manipulation sometimes don't realize what they're doing, and usually don't realize that you know what they're doing. A large amount of pride is invested in keeping up the front. It's tricky to let them know you see through their games, and at the same time convey respect for the person underneath the games.

What are some things you can say or do to help your clients save face while you refuse to be manipulated?

_____
_____
_____

Healthy Survival Skills

One of your most important roles as an outreach worker is your ability to model healthy survival skills. You are living proof that these skills work. Only as your client learns these skills, practices them, and gets comfortable with them will she feel safe in letting go of manipulation.

Here are a few healthy survival skills:

- **Assertiveness:** This is the opposite of manipulation. It's asking for what she wants and needs, pure and simple. The client needs to know that assertiveness isn't the same as aggression. It's a cooperative act.

  What are some ways of modeling assertiveness in your relationships with your clients?

  _____

  _____

  _____

- **Taking Responsibility for Mistakes:** This skill can be an enormous relief to someone who has spent years making excuses, dodging blame and guilt. The client needs to know that, when she takes responsibility for having made a mistake, the world doesn't end. Whatever the consequences of the mistake might be, they're probably less painful and less energy-consuming than the process of dodging responsibility.

  What are some ways of modeling responsibility-taking in your relationships with your clients?

  _____

  _____

  _____

- **Relaxation Techniques:** Fear, anxiety and anger are powerful forces leading toward any or all of the unhealthy survival skills. The client can learn to deal with the perceptions that lead to fear, anxiety, and anger (often perceptions of emotional danger) and the physical effects of these states (see the last section of the module called "Safety Tips for Outreach Workers"). As she questions her perceptions—and brings down the physical signs of fear, anxiety, and anger—she'll feel less threatened.

  What are some ways of modeling relaxation techniques in your relationship with your clients?

  _____

  _____

  _____

What are some other healthy survival skills that have been helpful to you or other people you've known, and how can you model these skills in your relationships with your clients?

_____

_____

_____

_____

4.4 Domestic Violence

Learning Objectives

1. Discuss the current trends among clients where violence, and domestic violence in particular, is concerned.
2. Identify some of the driving forces behind domestic violence and some of the patterns that it takes.
3. Discuss some of the risk factors for violence committed against others.
4. Discuss the outreach worker's responsibilities and role limitations where domestic violence is concerned.

Current Trends

Outreach workers and other Project SAFE staff have been noticing that domestic violence is becoming a larger and larger issue for clients. Most of the perpetrators of this violence are paramours who are themselves addicted to alcohol and other drugs. Some related trends:

- More women come from situations in which violence was an approved way of improving status and solving problems.
- Clients and the people in their lives are more and more desensitized to violence.
- More clients are involved in gang activity and carrying weapons.
- More clients have been assaulted by their paramours, and more have assaulted their paramours.
- More threats and confrontations are taking place among clients.
- More threats have been made to Project SAFE staff members.

If you've been doing outreach work for a while, what evidence have you seen that either supports or doesn't support these trends?

_____

_____

_____

_____

What factors in clients' past lives might be increasing their risk of domestic violence?

_____

_____

_____

What factors in their paramours' past lives might be increasing their risk of domestic violence?

_____

_____

_____

What factors in their communities might be increasing clients' risk of domestic violence?

_____

_____

_____

What factors in society as a whole might be increasing clients' risk of domestic violence?

_____

_____

_____

The Face of Domestic Violence

What do you see as the strongest forces or motives that lead one partner to use violence (physical, emotional, or sexual) against another?

_____

_____

_____

Where do these forces and motives come from, in your opinion or experience?

_____

_____

_____

What do you see as the strongest forces or motives that lead a client to stay in a situation where she's being abused, physically, emotionally?

_____

_____

_____

Where do these forces and motives come from, in your opinion or experience?

Many people believe that someone who uses violence against another is being driven by fear. That fear was often born long ago, in childhood—often in situations where he or she was abused or watched someone else be abused. In many cases those early experiences actually changed the way the person's brain functions. Those changes in brain chemistry make it harder to use self-control, and easier to misinterpret others' words and actions as threatening. They might not believe that others are going to hurt them physically. Instead, they might fear losing face, losing what they have, or not getting what they want or need.

Many people are taught that the only way to get relief from this fear is to try to control other people. Violence is one way of controlling people. What are some other ways?

Outreach workers speak of certain points in clients' recovery where their risk of getting beaten up by their paramours increases.

- One of these times is when clients get involved in treatment and start cleaning up and paying attention to how they look.
- Another key time is when clients begin to feel more independent, speak in more independent ways, and take care of their business.
- A third key time is when clients realize how destructive their relationships with their paramours are and start trying to get out of these relationships.

In your opinion, what is it about these times that increases the paramours' likelihood to use violence?

Recognizing the Potential for Violence

Violence is unpredictable, but it's often possible to tell whether or not a particular person shows a high risk of using violence against others. The following is a list of risk factors that have been found in people who have substance abuse histories and have used violence against others. As

you look at this list, think of the substance-abusing male paramour of a client, and see how many of these items you might check.

____ In childhood, he experienced abandonment, brutalization (severe physical abuse), and horrification (watching others be abused). These acts began early, happened over a long period of time, and/or were perpetrated by more than one person.

____ He has some history of setting fires, cruelty to animals, and bed-wetting in childhood.

____ He has a past history of aggressive and violent behavior.

____ He has a substance-related organic disorder that is lowering his level of mental functioning.

____ He has been diagnosed with, or shows symptoms of, a serious psychiatric illness that is associated with increased risk of violence.

____ He is currently showing signs of paranoia; feelings of being persecuted; and ideas that, if he acts them out, might result in violence.

____ He is very immature, has low self esteem, is very impulsive, and engages in risk-taking behavior.

____ He is jealous, controlling, and very sensitive to rejection.

____ He talks about his fears of "blowing up" or losing control.

____ He has no social supports, or has social supports that would encourage aggression.

____ He has no personal values strong enough to curb his violent urges.

____ He has made a specific threat toward an identified person.

____ He has guns or other weapons, or has access to them.

These are important factors to keep in mind in deciding whether or not you're safe in the presence of this person. You can also use them as guidelines in taking stock of the risk of violence by a client. These are important factors to talk about with your supervisor and any other staff who work with this client or paramour. The risk of violence is not one to ignore.

Your Responsibilities and Limitations

As much as you want to be able to keep your clients safe from any harm, there's only so much you can do if she's hooked up with a violent partner.

Here are a few steps that other outreach workers have taken:

- Bring in a speaker on domestic violence, possibly from a local hotline or shelter, to talk to staff and clients.
- Play videotapes about domestic violence for groups of clients, to show them that they're not unique and that there are ways of increasing their safety.

- Tell clients about local domestic violence shelters and take them to those shelters if they request it.
- If a client talks about domestic violence that is going on in her life, suggest that she tell her counselor about it so they can work on it in treatment, and mention it to the counselor yourself.

What are some other steps you might take?

_____

_____

_____

_____

_____

What steps would be beyond the limits of your role as outreach worker?

_____

_____

_____

_____

_____

What steps would be outside your personal comfort zone?

_____

_____

_____

_____

_____

If your client is living with or is visited by an abusive paramour, and if you or anyone else gives her any written materials on domestic violence, **make sure she doesn't take them home and leave them where her paramour might find them.** You might offer to keep the materials in the van for her. If she must take them home, strongly suggest that she hide them at the bottom of a Kotex box or a Tampax box. Most other hiding places—underwear drawers, coffee cans, etc.—aren't safe. Explain to her that violent partners tend to get more violent if they think their victims are thinking about leaving.

Victims of domestic violence tend to make up their mind to leave many times, and then return many times to the violent situation. Why do they go back? Recovery from victimization is a developmental process very much like recovery from addiction. Sometimes it takes several tries,

and there's just a little progress each time.

Consider the case of Rhonda, who has been in a relationship with Paul for several years. She's left him seven times, and come back. The violence has been escalating as she's made progress in treatment. He beat her up badly last night, and she's really fed up. She's been getting information on shelters and she has a shelter all picked out. She asks you whether or not she should leave. What do you say?

_____

_____

Some domestic violence counselors warn others in helping positions **not** to tell the client to leave the abusive partner, even if she seems ready to leave. This is because she's likely to change her mind again, either before or after leaving. When she does change her mind and decide to stay with him, she'll still remember that you told her to leave. She'll feel you judging her decision to stay. Part of her trust in you will be damaged. It's better to let her know it's her decision to make, and to urge her to talk to her counselor and a domestic violence counselor.

One of the comforts of the outreach worker's role is that you're not the counselor. You're not the final authority on the client's well being. You're the one who is there for her, who sometimes becomes part of the miracle because of your caring and consistency. But you don't have to save her. You can't save her. You can take care of your own safety and show her, by example, how to care for herself.

4.5 Safety Tips for Outreach Workers

Learning Objectives

1. Discuss a number of ways of getting information about the level of danger in a situation.
2. Discuss a number of measures that outreach workers have suggested to avoid dangerous situations or lower the level of danger.
3. Examine how fear affects your judgment and responses, and discuss ways of lowering the effects of panic and improving your responses in potentially dangerous situations.

Danger Zones

If you've been in outreach work for a little while, you know that many clients live in neighborhoods that sometimes seem like battlefields. Many clients' home environments also seem like battlefields, particularly if they're living with addicted partners with a history of violence. Even the inside of a client's mind can seem like a battlefield, with so many intense and conflicting thoughts, needs, and emotions.

You're an outreach worker, not a soldier, a super hero, or a sacrifice to the cause. As important as the client's well-being is, it's part of your job to put your own safety first. Avoiding a dangerous situation doesn't make you a coward or a failure. It makes you available to keep trying and helping, with this client and the next.

In order to avoid danger, you need to know about it. What are some ways of getting information about the danger you might face in a particular situation?

_____
_____
_____

What steps can you take to get this information from the referring DCFS case worker?

_____
_____

What steps you take to get this information from your supervisor or other Project SAFE staff?

_____
_____

How might you get this information from your own observations as you approach the situation?

_____
_____
_____

How might you get this information from your own body (your intuition or gut feelings)?

_____
_____
_____

The following exercises are designed to put you more in touch with your gut feelings of danger. Imagine yourself in these situations, and let yourself feel what you would be feeling.

You're going to visit a client in a neighborhood you've been in several times and never seen any trouble. It's a housing complex. There are people of all ages on the streets. There are elderly men sitting together on the lawns. There are children playing in the playground. Nobody seems to be paying attention to you as you pull up in your car.

What feelings do you have, in your stomach or chest, as you picture yourself in this situation?

_____
_____
_____

Now you're visiting the same client the following week. The elderly people and children you usually see here are gone today. There seem to be many people on the streets, mostly men, and many of them seem to have been drinking. The neighborhood seems louder than usual, and you feel a sense of something in the air, but you can't identify what it is. A group of men watches you closely as you pull up in your car.

What feelings do you have, in your stomach or chest, as you picture yourself in this situation?

_____
_____
_____

Now the next situation. You're in a large apartment building, approaching the door to your client's apartment. You can't hear any voices inside the apartment, just the sound of the TV.

What feelings do you have, in your stomach or chest, as you picture yourself in this situation?

_____
_____
_____

You're in the same apartment building, approaching your client's door. You hear very loud voices from inside the apartment. You recognize them as the voices of your client and her paramour. You can tell from the sounds that they're having an intense fight that is both verbal and physical.

What feelings do you have, in your stomach or chest, as you picture yourself in this situation?

_____
_____
_____

At times we've all found ourselves denying those uneasy gut feelings, out of a sense of duty or a fear of being silly, and regretting it later. When you've denied these feelings, what have you usually told yourself?

_____
_____
_____

Next time you find yourself denying your gut feelings in this way, what can you tell yourself to counter that denial?

_____
_____
_____

Safety Measures

Here are some pieces of advice from outreach workers and supervisors, some of whom have learned the hard way.

- "You have to watch the area, to see what's going on, before you even attempt to get out of the van."
- "Cruise the area and find out when it's a safe time to visit. Ask the client. 'I need to do this for 90 minutes every week, so you need to tell me when it's safe.' We've had women walk over to the drapes and give us a thumbs up, saying 'Come on in, it's okay,' or thumbs down or some other gesture to say, 'Get out of here!' We're going to respect your household; just keep us safe. If we notice something is going on, we'll say, 'Look, I noticed when I came in that this was going on and I'm not feeling comfortable. Can we go back to the office?"
- "I'd strongly encourage the outreach workers to trust their instincts. If you're feeling unsafe, leave. We'll go back later. We had an incident with an outreach worker who had walked through a gang of six men standing in front of a door. She mentioned later that she was a little nervous. I said, 'Go in the morning when the gang-bangers are asleep. You don't have to do it right then. She'll still be there and she'll still be getting high'."
- In general, home visits are much safer in the morning than in the afternoon.
- Don't go into dangerous areas alone. If a situation isn't safe to visit alone, visit in a team. If your site has any male outreach workers, work in a male-female team. If you tend to

panic in dangerous situations, tell your partner about it and tell him or her what to expect from you and how to get you out of it.

- If you're not ready to handle going into a particular situation, tell your supervisor about it. Someone else can handle that situation.
- Learn about the unofficial "rules" in public housing and take them seriously. Even if you used to live there, or go in there to buy drugs, it's different now that you're an outreach worker. "Coming in there as a professional, all of a sudden that whole idea turns around and you're the enemy."
- Public housing complexes aren't the only dangerous areas. Beware of houses that look abandoned, with boards on the windows or no sign of life inside.
- Pay attention to the racial makeup and feelings in the area. No matter what race you are, if you're the only one of your color in a racially tense neighborhood, you're in danger.
- Don't get boxed in. Always leave yourself an escape route in case things get violent. For example, if you're going into a house in a situation that might be dangerous, don't pull into a driveway where someone else could park behind you and block you.
- Don't wear expensive jewelry or clothes, don't carry a lot of money, and keep a secure hold on your purse (if you have to carry one).
- Learn and respect the cultural rules about eye contact, body language, speaking to strangers, etc. Learn the hidden language underneath these "languages," so you don't "say" the wrong thing to the wrong person.
- Always seem as confident as you can—by your look, your walk, your way of talking. Talk to your supervisor and your co-workers about this, and ask them to watch you on home visits. If you can't act confident in a situation and make it convincing, you're not the right one to go into this situation at this time.
- Even police officers will tell you that a domestic violence situation is the most deadly one for an outsider to enter. You can get attacked by either partner, or by both partners.
- Always keep a mobile phone with you, and a beeper, if you have one. If your program doesn't provide phones, try to get them. If your program can't afford them, volunteer to work on a plan to raise the money. If you know someone whose phone you can borrow (possibly your supervisor), borrow it when you pick up clients or make your home visits.
- The van can be a "hot" zone too, while the clients are being transported together. For example, one client may be seeing another's paramour, and sparks might fly. Clients who have fights in the van—particularly physical fights—put everyone in danger. The best way to deal with these issues is to try to prevent them. Have a strict "no confrontation" rule in the van. Tell the women to save these issues for group. If you know that two clients are having a conflict, don't let them sit near one another in the van. And if fighting of any kind starts, pull over until you can stop the fighting.
- "If someone is out of control, if someone is angry and shouting and distracting you from driving, you have a perfect right to pull over and say, 'You need to settle down before we can move any farther'."
- In transporting a dual-diagnosed client who might have violent tendencies, keep the

client near the front of the van where you can keep an eye on her. It's important to have these clients keep their purses on the van floor, so you can see if they start to reach for weapons.

- The use of seat belts in the car or van is an important safety issue. Some clients will try to take them off repeatedly during the ride, or their children will take them off and the mothers won't enforce the rule. Make sure you monitor this carefully and keep reminding them of the seat belt rule. If necessary, you can stop the van until they put the belts back on. If a client is pregnant she may have a strong desire to remove the seat belt for comfort. If possible, have her ride in the front seat so you can watch her more closely.
- Other rules are also important for keeping order and safety in the van or car. These include no smoking, no walking or dancing while the van is moving, no yelling out of the van window, no beating on the window, and no honking the horn to get the attention of people on the street or sidewalk. See the module on "Providing Transportation."
- You're responsible for keeping the van or car in good working order. Make sure it has its routine maintenance visits, and get problems checked and fixed before they turn into breakdowns. Make sure you know how to change a flat tire and have a good spare.

What safety tips of your own would you add to that list?

- _____
  _____
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  ___
- _____
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The Effects of Fear and Panic

One reason it's so important to avoid dangerous situations is that, once we're in danger, we can't think as well as we can the rest of the time. The physical effects of fear actually keep us from communicating with the parts of our brain that would otherwise tell us what our options are, what we should say, and what the consequences of our actions might be. And all this is happening at a time when we **really** need to know what our options are, what we should say, and what the consequences of our actions might be!

When you sense danger—physical danger or emotional danger—your body automatically starts pumping out quite a bit of adrenaline. You might know that's happening because you get certain physical symptoms. Sometimes your heart starts beating faster, your face gets red, your arms start to tingle, and you can actually feel the panic rising up through your stomach, into your chest, and up toward your throat. You might have a funny taste in your mouth, or hear the blood pounding in your head.

This reaction to fear is called "flooding," because your brain is being flooded with adrenaline. Flooding doesn't just happen when you're afraid. It happens when you're angry, too. It's interesting that the physical and neurological symptoms of fear and anger are the same. We know the difference between the two because of the way we interpret the situation.

Think of times when you've experienced flooding. What physical symptoms do you tend to get?

_____
_____
_____

When your brain floods with adrenaline (in the brain it's sometimes called "noradrenaline" or "norepinephrine"), several changes take place. Our brains function by having messages travel down what are called "neural pathways." In flooding, the adrenaline blocks the pathways that lead to the part of the brain that forms language. So we can't find even simple words that are easy to find at other times, or understand other people's words. The adrenaline also blocks the pathways that lead to the part of the brain that thinks of options and alternatives, and the part that predicts the consequences of our actions.
So we can't go to our language centers for help, or to the higher logic centers that will tell us what we can do and what will happen when we do it. What's left? Where can we go? Straight down, into the primitive parts of the brain that only know how to fight, freeze, or flee (run away). Usually we tend to choose one of these responses over the others, based on our own experiences and what worked best for us when we were children.

When you're flooding, is your strongest urge usually to:

_____ fight (physically or verbally),

_____ freeze (feel emotionally or physically paralyzed), or

_____ flee (to run or walk away physically, or to escape into your mind)?

What do you usually do when you get that urge?

_____

_____

How effective is this response in dealing with the danger you find in your work?

_____

What response, if any, would you rather have to these situations?

_____

_____

Four things are important to remember when you feel the physical signs of flooding:

1. This is flooding.
2. The adrenaline has taken over my brain, and I won't be able to think clearly as long as I'm flooding.
3. I can bring the flooding down so that I'll be able to think better.
4. The people I'm dealing with are probably flooding too. They probably can't think clearly either, and they probably won't understand what I say to them, no matter how smart they are—especially if what I'm saying requires that they use their logic or common sense.

To bring down your own flooding, try breathing slowly and deeply. Do some kind of large-muscle exercise. That helps clear the adrenaline out of your brain. If possible, do some running or fast walking, although sometimes the situation won't let you do this. But even if you can't safely make any visible movement, you can exercise your large muscles by pushing very hard on a wall, trying to pick up the chair you're sitting in, or pressing your arms very hard against your side. Do this for a few minutes.

Think of a past situation in which you were flooding and had trouble thinking clearly. What could you have done in that situation to bring down the flooding?

_____

_____

When you're with people who are flooding:

- Don't use any words, tones of voice, looks, or body language that they might see as aggressive (like pointing a finger, leaning toward them, putting your hands on your hips,

or shaking your fist).

- Don't show fear, through your voice, your face, or your body language (like clutching yourself, wringing your hands, looking down, or letting your eyes dart back and forth).

When you talk to people who are flooding, speak calmly, in a soft tone, in the lower notes of your voice, with no panic or hard edge to your voice. If you use any other tone of voice, they're going to interpret it as an attack—or an invitation to attack you! Their bodies are telling them to interpret you that way, and their brains are out of reach at the moment. It's important to practice this tone of voice in ordinary times, so that you'll be used to it when you really need it.

4.6 Ethical Issues in Providing Outreach Services to Women

Learning Objectives

1. Identify three basic questions that are part of effective ethical decision making.
2. Apply a model of ethical decision making to case studies that involve the following issues: confidentiality, self-disclosure, dual relationships, and duty to warn/intervene.

Definitions

An outreach worker's decisions and actions might be judged in a number of ways by a number of people and agencies. Some of them will be judged right or wrong, wise or unwise, successful or unsuccessful. These judgments often have to do with the ethics of your profession. In the space below, define the following terms, making clear the differences among them:

Immoral:_____

_____

Illegal:_____

_____

Unethical:_____

_____

Professionally

Inappropriate:_____

_____

This module is about the third one of those concepts, the idea that an action is ethical or unethical.

When we speak of ethical or unethical behavior, we're generally speaking about how to avoid doing harm to individuals, institutions, and communities—whether or not that harm is intended. Service relationships have a high potential for harm because of the unequal power that exists there: the client's vulnerability and the staff person's potential power to do harm.

The relationship between an outreach worker and a client is different from other relationships the outreach worker may have, because the service relationship is *fiduciary*. This means that the

outreach worker has taken on a special duty to and obligation for the care of the client. By taking on the role of outreach worker, you've pledged to the client to act in a highly professional manner and in the client's best interests. Many difficult ethical issues can arise as one tries to fulfill this fiduciary promise.

In medicine, unintentional harm caused in the process of trying to help is referred to as an *iatrogenic* illness—a physician-caused or treatment-caused injury. The goal of this section is to lower the risk of any iatrogenic effects that could result from the delivery of outreach services to women.

A Model of Ethical Decision Making

For the purposes of this training, you'll be introduced to a three-step model of ethical decision-making. In this model, you ask three questions in the face of an ethical question, problem, or dilemma:

1. *Who will gain and who will be (or could be) hurt in this situation?*

   This question reflects the understanding that the actions of an outreach worker have the potential to harm a number of parties: the client and her children, the outreach worker, the agency (which could include both the service agency and the funding agencies), the profession, and the broader community. This question also reflects the understanding that the interests of one party can conflict with another. Clarifying these interests and their potential conflicts is the essence of ethical decision-making.

2. *Are there any universal values that would apply to this situation? What course of action would each value dictate?*

   In White's 1992 book on ethical issues in addiction treatment, he identified the following seventeen values that repeatedly appear imbedded within the ethical standards of professional disciplines.

   Universal Values in a Professional Codes of Ethics

   - Autonomy (Help people find freedom in fulfilling their personal destiny.)
   - Beneficence (Help others.)
   - Competence (Be knowledgeable and skilled.)
   - Conscientious Refusal (Disobey illegal or unethical directives.)
   - Diligence (Work hard.)
   - Discretion (Respect confidentiality and privacy.)
   - Fidelity (Don't break promises.)
   - Gratitude (Pass good along to others.)
   - Honesty and Candor (Tell the truth.)
   - Justice (Be fair; distribute by merit.)
   - Loyalty (Don't abandon.)
   - Non-maleficence (Don't hurt anyone.)

- Obedience (Obey legal and ethically acceptable directives.)
- Restitution (make amends to anyone you've injured.)
- Self-interest (Protect yourself.)
- Self-improvement (Be the best that you can be.)
- Stewardship (Use resources carefully and appropriately.)

3. *What laws, policies, procedures, or other directives would apply to this situation?*

   The third question you'll ask in sorting through an ethical dilemma focuses on the kinds of guidelines that may already exist for this exact purpose. These guidelines might include everything from state and federal laws and regulations, to agency policies and procedures, to memos or spoken instructions from your supervisor related to this particular type of situation.

As you follow those steps, it's suggested that you use the following general guidelines in situations that pose the greatest risk of injury:

1. Get advice from appropriate people in your agency as soon as possible.
2. When advice from outside authorities is necessary or appropriate, seek such advice.
3. Document both the ethical issues that you've identified and your reasons for making those decisions.
4. Review the incident later in order to see what you or others can learn that can guide staff in future situations.

The following are ethical case studies that can be used to test this model of ethical decision-making.

Ethical Case Studies

Credentials

There is a general ethical rule that states that professionals must accurately represent their education, training, and experience. Joan, an outreach worker who hasn't had any formal training in counseling, often tells new people that she meets in her personal life that she works as a "counselor." Is this a violation of ethical conduct? Who could be hurt by this seemingly minor indiscretion? Apply the decision-making model above to this situation.

Confidentiality

A client who has just started treatment today tells you that there's something she really wants to talk to you about, but that you have to promise not to tell anyone else. How do you respond?

Mary, an outreach worker who is a member of a twelve-step recovery program, attends a meeting at which one of her clients is present. The client, who has told the program staff that she has remained drug free while in treatment, says in the NA meeting that she's

been using cocaine for the past week. Can Mary disclose this information to her fellow staff members? If you were the outreach worker, how might you handle this situation?

Sharid worked with you as a fellow outreach worker until she took a job with another agency. When she left two weeks ago, she transferred a case to you for continued services. This case involves a client named Rene with whom Sharid has developed a close relationship. You run into Sharid today and the first thing she says to you is, "How's Rene?" What do you say?

On a weekend outing with your family, you run into a client from the agency who greets you briefly and then leaves. Your family turns to you and asks, "Who was that?" How do you respond?

Self-Disclosure

Jane works as an outreach worker serving addicted women, and spends a lot of time sharing her "story" with clients. This self-disclosure could be called Jane's preferred "counseling" style. The self-disclosure includes quite a few intimate details about Jane's life experiences. One could argue about whether or not this kind of extensive self-disclosure is clinically effective, but are any ethical issues raised by this practice? Apply our three-step ethical model of decision-making to this situation.

You've been given the name of a client who called the agency about entering the women's treatment program. When you call the number that the client left, you're told that she's not there. The party on the line then asks who you are. How do you identify yourself, if at all, and what message do you leave, if any?

Dual Relationships

Today Tanya has been given the name of a new client whom she's supposed to contact about entering the treatment program in which Tanya is employed as an outreach worker. She recognizes the client's name as that of a woman who has been intimately involved with Tanya's ex-husband. Apply the three-step model of ethical decision-making to Tanya's situation. If you were Tanya, what would you do?

Margaret works as an outreach worker and sells cosmetic products on the side to make extra money. Recently Margaret has been offering these products to clients at a discount. Is this a service that clients appreciate or an ethical violation on Margaret's part? What kinds of problems, if any, could arise from this practice?

Allegations of Unethical Conduct

You're at a community reception on Saturday night talking with a cluster of nine people. When you introduce yourself and say where you work, someone next to you turns and says loudly that that must be a very interesting place to work because her neighbor, who is a client at the agency, has been describing the ongoing affair the client is having with her counselor. The lady reporting this mentions both the name of the client and the name of the counselor. You now have nine people turned to you, waiting for your response. What do you say? What actions, if any, should you take before leaving the reception? Should you—and would you—report this allegation to a supervisor at your agency? What if the allegation was about your supervisor? Would you report it to the person about

whom the allegation was made? How would you respond to casual, "How was your weekend?" inquires from other staff on Monday morning? Apply our decision-making model to this situation.

Duty to Warn/Intervene

In the course of making home visits and transporting mothers and their children, outreach workers have opportunities to observe many things that are cause for concern. Some of these situations inevitably involve a conflict between loyalty to the client and client confidentiality on one hand, and one's ethical and/or legal duty to intervene to protect the client's children on the other. Describe how you would respond to seeing the following during a home visit:

1. *An empty refrigerator*
2. *Piles and piles of dirty clothes and dirty dishes, both of which appear to be infested with many kinds of bugs.*
3. *Bruises on a client who hasn't been to treatment in three days.*
4. *Dark marks on a child that look like abrasions or burns.*
5. _____

You're making morning rounds picking up clients and taking them back to the treatment center. When you get to Martha's house, she runs out to the van and says that her babysitter hasn't arrived yet but should be there in a few minutes. As she steps into the van, Martha says, "Let's go ahead; I'm sure the kids will be fine until she gets here." How would you respond? Apply the decision-making model to this situation.

This morning in group, a client becomes very ill and starts spitting blood. You have no knowledge of this client's HIV status. Describe your response to this situation as you and several clients in the group approach her to offer assistance.

Relationship Boundaries

Many people interviewed in the preparation of this manual commented on the vulnerability of outreach workers in their relationships with clients. As one supervisor noted:

I think outreach is one of the most difficult roles in human service. As a therapist, you're not in the person's home and you're not required to cross those boundaries into the client's personal life. But as an outreach worker you are out there in their home and interacting with their children and their partners, and yet we do very little to help outreach workers figure out how they can maintain a zone of emotional safety for themselves while they are in such situations. We just sort of throw them out there and rely on their instincts.

In this section we hope to provide a safe arena in which you can explore some of the boundary issues in the relationship between the outreach worker and the client. Review the list of behaviors below and place a letter before each one indicating whether you think that behavior is:

A (Always okay for an outreach worker), S (Sometimes okay for an outreach worker) or N (Never okay for an outreach worker).[1]

___ Giving a client your home phone number

___ Hugging a client

___ Kissing a client

___ Visiting a client at night

___ Inviting a client to your home

___ Keeping a homeless client in your home overnight

___ Lending personal money to a client

___ Developing a personal friendship with a current client

___ Developing a personal friendship with a former client

___ Having a sexual relationship with a current or former client

___ Helping a client clean her house

___ Transporting clients in your personal vehicle

___ Taking a client's dirty laundry home with you to wash

___ Having an intimate relationship with a family member of a current or former client

___ Accepting a gift from a client

___ Giving a gift to a client

___ Helping a client move from one apartment to another

___ Hiring a client to do work for you

___ Serving as an AA, NA, or CA sponsor for a client

___ Socializing with a client away from work

Reading Resources

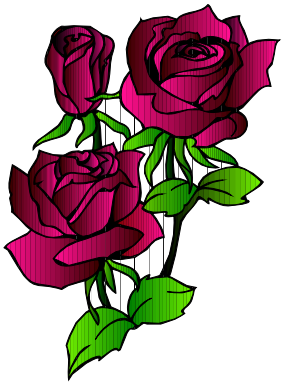
Bissell, L. And Royce, J. (1994) *Ethics for Addiction Professionals* Center City, MN: Hazelden.

Milgrom, J. (1992) *Boundaries in Professional Relationships* Minneapolis, MN: Walk-In Counseling Center.

Peterson, M. (1992) *At Personal Risk: Boundary Violations in Professional-Client Relationships* New York: W.W. Norton & Company.

[1] The design for this exercise comes from Jeanette Hofstee Milgrom's excellent manual, *Boundaries in Professional Relationships*.

White, W. (1993) *Critical Incidents: Ethical Issues in Substance Abuse Prevention and Treatment* Bloomington, IL: Lighthouse Institute.



Section 5.0

Professional Development Issues

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5.1 Time Management

Learning Objectives

1. Discuss the time constraints imposed on the treatment process by managed care and the effects of these constraints on time management for outreach workers.
2. Take an inventory of how you currently use your time.
3. Discuss time-management techniques that have been used successfully by outreach workers.
4. Discuss people-pleasing, workaholism, and procrastination, and their effects on time management.

Outreach Under Managed Care

Outreach workers who have been involved in the project since its early years have seen a drastic reduction in the number of hours women can spend in intensive outpatient treatment, down to the 75 hours now allowed by Managed Care. This puts more pressure on clients—many of whom are too wounded to do much more than get **ready** for treatment in 75 hours. It increases the danger that women will feel abandoned by a treatment system that was designed to give them the time-intensive nurturing that they need.

Because of these time limits, many of the clients' treatment and case management needs have been spilling over onto the outreach workers. In terms of skill, knowledge, and motivation, the outreach workers have no trouble handling these extra responsibilities. But in sites whose client lists are full, it adds to the time pressures in an already demanding job.

If you were an outreach worker before Managed Care, how has your job changed as the length of treatment has changed?

_____
_____
_____

What changes have you had to make in what you do in order to keep up with these changes?

_____
_____
_____
_____

Your Time-Management System

Before looking at possible ways of improving your time management system, please take a quick

inventory of your current system. If you're brand-new to outreach, fill in as much information as you can based on the information you've been given.

How many clients are on your current caseload? _____

How many clients do you see on an average day? _____

What's the highest number of clients you've had on your caseload? _____

What's the lowest number of clients you've had? _____

What are your usual working hours (start time and end time) in a day? _____

How many days a week do you work? _____

There's no such thing as a "typical" day; but if there were one, how would you describe it in terms of your time use?

Start Time	**End Time**	**Total Time**	**Name or Type of Activity**
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

When do you usually make phone calls? _____

When do you usually log your activities? _____

When do you usually talk to your supervisor?

_____

When do you usually meet with the treatment team? _____

When do you usually do your urine drops? _____

When do you usually take your breaks? _____

If you have trouble setting priorities, who helps you with that? _____

On a scale of 0 to 10, how comfortable are you with time management? _____

What part (or parts) of time management are still the most difficult for you?

_____

_____

_____

Where might you go to get help for these problems?

_____

_____

Time Tips from Outreach Workers and Supervisors

Of all the subjects outreach workers and supervisors were interviewed about, time management was the one they had the least to say about. That might mean that time management in outreach is no problem, or it might mean that everybody's so busy they haven't had time to think about it. It's probably the latter—that people are so busy *doing* that they don't have time to examine what they do and how they might fit it in more comfortably. As one outreach worker said, "It's a hard, demanding job."

Here are a few tips from outreach workers and supervisors:

- Log your activities as you do them, or as soon after as possible. Don't count on remembering things later.
- Bill from your daily log sheets as the activities take place. Don't wait until the end of the billing period. You'll drive yourself and your supervisor nuts. It will be much less painful if you get it done a little at a time.
- Billing on a daily basis is also a good way to keep an eye on how much of your time is being used by which clients. If a particular client is taking up a high percentage of your time, you know something's wrong. It could be that either you're being manipulated, or this client needs more intensive services in another area of treatment.
- Keep notes on all the things that need to be done. Use pads that have copies, so when you write a note to someone else, you can keep a copy for follow-up. In weekly meetings, check off all the things that have been done and make plans for the ones that still need to be done.
- Keep a calendar with notes on which clients showed up, which ones didn't show up and why not, new referrals, what you've been doing, anything significant that was going on, etc. This calendar can be used by all Project SAFE staff at your site. You and the other staff can develop a code system, so you don't need much space to chart these things. It will help you with your record keeping and help other staff with charting.

- Work together with your supervisor on setting clear and effective priorities. You can help one another.
- In many areas, home visits are usually much safer in the morning than in the afternoon. Become familiar with the areas you're visiting, and schedule your visits for the safest times. Make sure you work with your supervisor on this, so everyone understands this scheduling need (see the module on "Safety Tips for Outreach Workers").
- Make your phone calls to clients early in the morning, then communicate with your supervisor and make a list of what you need to do. Then go on home visits, and/or pick up clients and get them on site in time for their sessions. While clients are in session, make your phone calls to DCFS, process your drops, and review your daily list from this morning.
- Schedule in enough break time to avoid burnout!

Which of the tips listed above seem possible for you, and seem like they might help in your time-management efforts?

_____
_____
_____

Are there any of those tips that wouldn't work for you at all? If so, why wouldn't they work?

_____
_____
_____

What time-management tips would you add to the lists above?

- _____
  _____
  _____
  _____
  _____
  _____
  ___

People Pleasing, Workaholism, and Procrastination

For many people, even the best time-management systems are only partly effective, because the main problem is not the amount of work or the way it's been prioritized. The problem is in their relationship with work. Of these kinds of troubles, the three most common are people pleasing, workaholism, and procrastination. Sometimes they show up together, and sometimes separately.

- *Dora is an outreach worker who can't seem to say "no" to anyone. She always seems to be making unscheduled trips for clients, and sometimes spends a lot of time with one or two particularly needy clients. Whenever her supervisor—or anyone else—asks her to take on more work, she agrees to do it, even if she has her doubts about whether or not she can handle it. If a client or a co-worker stops her in the hall at the Project SAFE site, she feels as if she has to talk to that person until that person is ready to stop talking, even if there's somewhere else Dora is supposed to be. When Dora is home, she's always doing whatever her children want, and never takes any time to do the things she's always wanted to do. She walks around feeling resentful and frustrated much of the time, but doesn't want to say anything to anyone about it, for fear that they wouldn't like her. If you haven't guessed, Dora is a people-pleaser.*
- *Demaya is the best outreach worker at her site. She has a client load of 14, she works an average of 13 hours a day, and she often works on weekends. She never takes lunch breaks, and talks to her co-workers only when it's necessary to touch base on work matters. She often does work that's supposed to be referred to other staff. When people ask her why she didn't refer the work, she says "It was easier to just do it myself. Really, I don't mind." Demaya drinks a lot of coffee and takes a lot of antacids. She spends as much time with her family as she can, but her marriage is suffering because there never seems to be enough time to work through the everyday conflicts and problems that married people have. Everyone at work tells Demaya that she's a workaholic. Her supervisor tells Demaya her that she's concerned about her work patterns, but in the next breath she praises her superior performance. Everyone at work respects her.*
- *Cindy always seems to be doing things at the last minute. She's often late on her home visit and transportation schedules. She fills out her daily activity logs late, often making up entries because she doesn't remember exactly what she did. She gets her billing done in the last few minutes of the billing period. She feels anxious and guilty every time she does something late, but she still keeps doing it that way. The more anxious and guilty she feels, the more she gets behind. Cindy ends up spending extra hours at work catching up, then resents the fact that she doesn't have enough free time. Her house is a mess. She keeps waiting for a good stretch of time when she can clean it completely, top to bottom, but that time never comes. She avoids making plans with friends so she'll have more time for work and housework, but she ends up spending a lot of time zoning out in front of the TV and eating Cheetos. She really wants to get some help for her procrastination problem, but she keeps putting it off.*

What do these three women have in common? They expect far too much of themselves. Those expectations cause quite a bit of anxiety. They react to that anxiety in different ways.

- **People-pleasers** expect to be cooperative, helpful, and likeable to everyone, all the time. They're afraid of making anyone angry or having anyone dislike them. If they disappoint someone, it feels the same as if they had hurt that person. They try to do what people want them to do, and to tell people what they want to hear. They think that they're the only ones who suffer, but the people closest to them are pretty frustrated. They can sense the people-pleasers' hidden frustration and resentment. They never know if what they're hearing is the truth, or if it's just what the people-pleasers think they want

to hear. A people-pleaser's work schedule is never definite. It's always subject to change depending on who wants what right now. It's hard for the people-pleaser to set limits and stick to them, and it's hard for the supervisor to deal with this lack of clear boundaries.

How much (if any) of the people-pleaser do you have in you? How does it come out in your work?

_____
_____
_____
_____

Hope for the people pleaser comes in practicing saying "no." It comes in learning that disappointing people is not the same as hurting them; that telling people only what they want to hear is cheating them out of the truth; and that people may like you if you compromise yourself for them, but they'll never respect you. Often the psychological roots of people pleasing run deep, and therapy is necessary before the behaviors can change in any meaningful way.

- **Workaholics** expect tremendous things of themselves—great achievements, the highest performance, and no mistakes. These expectations create quite a bit of anxiety. The only way they know to relieve that anxiety is to work longer and harder. One other thing is also relieved during their working hours: it's a way to avoid the discomfort of working through the conflicts and problems of everyday life in intimate relationships with other people. The people who try to have intimate relationships with them often feel angry, cheated, and neglected. In the case of their children, this can do some psychological damage. But their organizations and supervisors reward them for their addictive relationship with work. They may express concern for the workaholics' health, but there's always that other message: "We couldn't do it without your extra effort."

  How much (if any) of the workaholic do you have in you? How does it come out in your work?

  _____
  _____
  _____
  _____

  Hope for workaholics comes in looking honestly at their expectations of themselves and the origins of those expectations (usually in their childhood). As long as they expect far too much, the anxiety will drive them to work far too hard and too long. Workaholics also need to look at the effects of their work patterns on their relationships, and to ask themselves if the work is worth the damage it does in the rest of their lives. They need to look at the tasks of intimacy that are uncomfortable to them, and to see how much that discomfort is prompting them to use overwork to avoid those tasks. Usually therapy is a good idea. Workaholics also need to force themselves to take breaks. They need to schedule leisure time and stick to that schedule, no matter what else needs to be done. Sometimes it might help to talk to a few other workaholics who have been forced by

heart attacks, bleeding ulcers, chronic fatigue syndrome, etc to take it easy.

- Believe it or not, **procrastinators** are usually driven by the same high expectations of themselves as workaholics. They expect to do monumental things, and to drive themselves relentlessly until they're done. They make plans to do everything non-stop, and to work impossible hours without a break. Those expectations set up intense anxiety in them. Their pattern is to handle that anxiety by escaping it—by wasting time, by doing other things, by getting caught up in conversations, by goofing off, etc. The more they goof off, the higher their anxiety gets, and the more they need to escape. When the deadline gets close enough, they put in super-human effort to get everything done. They end up exhausted, expecting even more of themselves, and fearing the next deadline just as much as they did this one.

  How much (if any) of the procrastinator do you have in you? How does it come out in your work?

  _____
  _____
  _____
  _____

  Hope for procrastinators comes in realizing that they're not just basically lazy, as they'd always feared. Their problem lies in their impossible expectations of themselves. They need to look at the origins of those expectations, and to work on lowering expectations to a manageable level. They need to schedule breaks, free time, and leisure activities for themselves, so the future won't look like a prison of work that they have to try to escape. They also need to make sure not to make any commitments they can't keep.

  A good book for procrastinators is *The Now Habit* by Neil Fiore (Los Angeles: Jeremy P. Tarcher, Inc.).

In looking over these descriptions, do you see anything that you might change in your work and leisure habits? If so, what?

_____
_____
_____
_____
_____
_____

It's a good idea to share your answers to this module with your supervisor, who might be able to help you work on some of these things. If your project has more than one outreach worker, you could even work together as a team to develop a time-management system.

5.2 Living the Message: Stress, Strain, and Strategies of Self-Care

Learning Objectives

1. Identify at least three early warning signs of personal/professional stress.
2. Recognize at least two professional situations that raise your personal vulnerability.
3. Describe at least three strategies that you can use to manage personal stress.

Stress and Burnout in Providing Outreach Services

Stress and frustration exist in many areas of human service, but outreach workers at women's treatment settings may be subject to some special types of strain. In the space below, identify at least three aspects of outreach work that cause different kinds of stress than you would experience in other human-service roles.

1. _____
   _____
   _____
2. _____
   _____
   _____
3. _____
   _____
   _____

Early Warning Signs

In order to manage stress in the outreach worker's role, you need to be able to recognize the early warning signs of excessive stress. Each of us over a lifetime has developed unique vulnerabilities to stress, a unique style of responding to stress, and a unique pattern of early warning signs that tells us our traditional style is beginning to break down. In the space below, identify the categories of symptoms that are most typical of your **earliest** warning signs of stress:

___1. *Health*: Fatigue, colds, fever blisters, headaches, sleep problems, stomach problems, muscular pain, excessive sweating/urination, the flare-up or worsening of existing medical conditions.

___2. *Excessive Behavior*: Using more caffeine, tobacco, alcohol, or other drugs; eating more or less; becoming more irritable and/or aggressive; gambling; going on shopping sprees.

___3. *Emotional Adjustment*: Extreme mood swings, paranoia, emotional withdrawal, depression, tendency to cry, increased daydreaming, undefined fears, feeling of being trapped, guilt feelings, intolerance.

___4. *Relationships*: Isolation, over-involvement, increased conflicts with co-workers and friends, increased strain in family relationships.

___5. *Attitudes*: Boredom, cynicism, sick humor, hyper-criticism of others, negativity, feelings of hopelessness and frustration.

___6. *Other*: _____

High-Risk Situations

Outreach workers are also different one from another in the kinds of situations they find most difficult. Listed below are a number of situations that outreach workers have encountered. Place a check mark by the three that you, personally, would find most difficult to handle.

___ A prospective client fails to agree to come to treatment

___ A client relapses

___ A client delivers a drug-exposed infant

___ A client neglects/abuses her child

___ Conflict with a co-worker

___ A client stays in a destructive relationship

___ A client refuses to involve herself in AA or other appropriate Twelve-Step/support groups

___ A client's home is crawling with bugs

___ Clients argue with each other in the van

___ A client dies

___ Threats to personal safety

___ Fear of funding cuts and loss of your job

___ _____

___ _____

Replenishing Hope

Some studies have found that people in the helping professions are particularly vulnerable to burnout when they lose their sense of idealism—their belief that what they do is going to make a difference. As you learned in the module on "Realistic Expectations," focusing on the small successes in clients' lives can help you keep your sense of hope and accomplishment alive. What are some other ways you might keep your sense of hope and idealism alive?

1. _____
_____
_____

2. _____
_____
_____

3. _____
_____
_____

Decompression Rituals

Decompression routines are rituals that tell us and others that one part of our daily life (professional) is ending and another part (personal) is beginning. Ideally, decompression rituals take place in the 90 minutes surrounding this transition. In the space provided below answer the following questions.

1. What things do you routinely do at the very end of the day before you leave the workplace that help you bring your professional day to a close?

   _____
   _____
   _____

2. What things do you do between leaving your agency and entering your home that help you leave work at work and focus on your personal life?

   _____
   _____
   _____

3. What things do you do in the first hour after you get home that help you shed your professional role and enter your private life?

   _____
   _____

_____

After reviewing the above list, answer the following statements about the activities you've named, by circling YES or NO.

YES NO 1. They help me leave work stress at work.

YES NO 2. They include some kind of physical activity.

YES NO 3. They involve me with people with whom I'm comfortable expressing strong emotions.

YES NO 4. They include things that give me a great deal of personal pleasure or satisfaction.

YES NO 5. They don't cause other problems in my life (for example, if I'm trying to keep my weight down and I need to eat a chocolate sundae every day at 6:00 in order to unwind, it probably is causing problems in my life.

Centering Rituals

Centering rituals are short time-out periods that can help us stay focused on our personal values. These are activities that we do alone that help us remember what's most important in our lives. Centering rituals can keep us from getting overwhelmed and "off course" from our primary service mission. These rituals can include prayer, moments of quiet reflection, special meditative techniques, reading particular pieces of literature, listening to inspirational songs, or going for short walks.

The centering rituals I use most frequently include: _____

_____

_____.

Social Supports

Outreach workers can work under very high stress conditions for very long periods of time as long as they have a rich network of supports to sustain them in this work.

In the space below, list the names of at least two people in each of the following categories. Some will be easy to fill in, and others may be difficult.

1. Professional supports at work. (These are people who provide personal or technical support that helps you do your job and feel good about where you work.)

   a. _____ b. _____

2. Professional supports outside of work. (These are people who work in your field but don't work at your agency, from whom you get support and with whom you can "talk shop.")

   a. _____ b. _____

3. Mentors. (These are very special people in your profession whom you admire and who have encouraged you professionally and personally. They can be from inside or outside your current agency.)

   a. _____ b. _____

4. Family supports. (These are people in your family and intimate social network who give you support when you go home from even your worst days at work.)

   a. _____ b. _____

5. Non-work social supports. (These are people with whom you socialize regularly but who don't work at your agency. P.S.: When you're with them, you don't spend all of your time talking about work.)

   a. _____ b. _____

Look at the lists above. Which were the most difficult to fill in? Are there areas in which you need to concentrate on developing new supportive relationships?

Acts of Self-Care

In a service profession, it's sometimes hard to step back and focus on our own unmet needs. We see people whose needs are so many and so intense that we can even feel guilty for focusing time on our own needs, interests, and pleasures. But long-term effectiveness as a service provider requires that we replenish ourselves physically and emotionally—that we find ways to recapture our own pleasure in living. You can do this through simple acts of self-reward, experiences that remind you that your own needs are legitimate and worthy of your time and resources. In the space below, list five things that you can do in the next month as acts of self-care.

1. _____
2. _____
3. _____
4. _____
5. _____

Acts of Service

It might seem strange that people whose professional work is to provide services to others can

find acts of service in their personal lives replenishing. But that's what interviews with some of our outreach workers in Illinois suggests. Several outreach workers said that service activities in their personal lives helped reinforce the fact that their work as outreach workers is much more than a job. They saw private acts of charity and service as a way to remind themselves why they were drawn to outreach in the first place. They also emphasized that it was important that the type of the service be different from the work that they did in their jobs. Acts of service can include things like volunteering for a community agency, service activities through your church, offering assistance to a stranger in need, or simply helping a friend or neighbor. Is there a kind of service activity that you're interested in but you've never pursued? If so, list it below.

Area of Service Interest _____

_____

How might you pursue this interest?_____

_____

_____

Advice from other Outreach Workers

In preparing this curriculum, we asked several outreach workers to comment on the stress they experienced in their jobs and how they handled it. Here are some of the things they said:

> *It's easy to get caught up in all kinds of unrealistic expectations working with these women, and then you find yourself getting overwhelmed and asking, "Are we making any difference?" What I've learned is that you have to stay focused on the potential for hope. You have to define your work in terms of small successes that can add up to big successes. I have a woman who just delivered a drug-free, healthy baby and all I could think of was, "We made a difference with this one!"*
>
> *My stress lowered when I figured out that these clients were not my kids—that they had to learn things on their own. It was then that I could stop taking too much responsibility for what they did or didn't do. I'm not superwoman. I can't cure anybody—I can only support them and be there for them while they cure themselves. It took me quite a while to figure this out. I stopped trying to be perfect and started trying to just consistently be there for them.*
>
> *I do two things. First, in the morning, I try to focus on nothing but my son. I don't think of anything related to work until he leaves for school. That focus reminds me what's most important in my day. Then at the end of the day, we have about thirty minutes after we've dropped the clients off before we get off work. The other outreach worker and I use that time as a winding-down period. We talk about what happened in our day—what was good and what was most difficult. That helps me leave stuff at work and not carry it home with me.*
>
> *For me, it's my relationship with God. I think it's important for an outreach worker to have a spiritually based life. Outreach is hard and you have to have some type of*

relationship for yourself. In order to give what we give to our women, you have to have something to give away. If you're not being spiritually fed, it's hard.

For me, I need to make meetings. I can't give away what I'm not doing. I can't tell them they need to make meetings if I'm not going to meetings. It is also important for me to separate who I am as a recovering person and who I am as an outreach worker and to keep this distinction clear in my relationships with the women. There are times I step out of my professional role and talk to them addict-to-addict, and other times I let them know I'm giving them a professional recommendation. Keeping the roles straight is important for me and for them.

My major source of support is the other outreach worker I work with. We encourage each other and, when we need to, confront each other. To keep doing this work for any length of time, you have to have that base of support within the staff.

You've gotta take time out. I just gotta get away sometimes for rest and perspective. And I got a counselor myself. Oh, God, that killed me! That hurt my pride, but I had to do it. That's what helped me hang in so long.

You've got to be willing to give a little, take a little, close your eyes a little, bend a little.

It's okay to burn out as long as you don't make an ash of yourself!

Personal Action Plan

This training is designed to give you an opportunity for professional and personal self-reflection. Review the items below and place a check-mark beside the steps you need to take in order to improve your ability to manage personal and professional stress:

___ I need to see a physician for a thorough physical check-up or to get active treatment for conditions I've been ignoring.

___ I need to improve my diet by choosing healthier foods and taking in less cholesterol, fats, sugar, and salt.

___ I need to establish and stick to a regular program of exercise.

___ There are toxic habits, such as smoking, that I need to eliminate from my life.

___ I need to learn some specific techniques to help me manage particularly stressful events.

___ I need to set more effective limits on myself and reduce my commitments.

___ I need to learn how to express my frustration more effectively, and not keep it bottled up.

___ I need to develop new supportive relationships.

___ I need to develop better decompression rituals to keep my work-related stress from spilling over into my personal life.

___ I need to develop a few centering rituals to help me stay focused through each workday.

___ I need to spend more time cultivating leisure-time enjoyments.

Review the items above that you checked. Is there one to which you are ready to commit yourself to action? If so, fill in the following statement.

IN THE NEXT MONTH, I WILL _____

_____

Reading Resources

Davis, M. Eshelman. E. And McKay, M. (1989). *The Relaxation and Stress Reduction Workbook*. Oakland, CA: New Harbinger Publications.

Freudenberger, H. (1980). *Burnout.* Garden City, New Jersey: Anchor Press.

Pelletier, K. .(1977) *Mind as Healer, Mind as Slayer: A Holistic Approach to Preventing Stress Disorders.* New York: Delta Publishing.

White, W. (1986) *Incest in the Organizational Family: The Ecology of Burnout in Closed Systems* Bloomington, IL: Lighthouse Institute.

5.3 Career Mobility

Learning Objectives

1. Discuss the value of the outreach worker's role—to the client, to Project SAFE, and to the treatment field as a whole.
2. Discuss other outreach workers' ideas and observations on possible career paths.
3. Identify your own career goals and the steps that would be necessary in order to achieve them.

The Outreach Worker's Role

It's interesting to look at how the outreach worker's role is valued, and how that value is expressed. It's not a very highly paid role, because it's an entry-level job that doesn't require much education, training, or work experience. Still, it's a role that most people—education or no education—couldn't fill. It takes a combination of inner qualities that most people don't have and couldn't get through training, education, or work experience.

Outreach is also a role that has profound impact on many lives—the lives of clients and of their children. Clients have said, in no uncertain terms, that if it weren't for their outreach workers they wouldn't have entered or stayed in treatment. Given the Project SAFE client population, this would in many cases mean death, the loss of their children, or further child abuse or neglect.

The importance of your role to the treatment field is also clear. The overall client population shows ever-greater numbers of dually diagnosed patients, earlier onset of substance abuse and addiction, and lower levels of functioning among clients.

Developing generations of addicts are being subjected to even worse abuse, neglect, and exposure to violence than were their predecessors who are now in treatment. "Take-it-or-leave-it" treatment won't work when these generations are ready to hit bottom. Society will have to pay the relatively low cost of the kind of outreach you're pioneering, or pay a much higher cost in rampant crime, violence, prison accommodations, public health emergencies, and the placement of countless abused and neglected children.

What trends do you see in your work, and how do you think they'll affect the future of treatment?

_____
_____
_____
_____

How do you think the outreach role could be taken into other parts of the field?

People in Project SAFE have talked about "professionalizing" the outreach worker's role. This would include giving outreach workers more training and education benefits, increasing salary scales, and creating career paths through agencies. What would that mean to you?

Possible Career Paths

Many outreach workers who were interviewed said they liked the work they were doing. "I'm happy where I'm at," said one. "I've thought about . . . being a therapist. It's not what I want." About the outreach role, she said, "I like that freedom. I like going out and meeting these women and working with them and sharing what I know. There is just so much involved."

Others stressed the importance of getting more education and training in the outreach role. "You can never learn too much. And whatever you learn today is obsolete. You need to continue to grow," said one woman. Another mentioned the importance of continuing her own education as an inspiration for her clients. Continuing education, workshops, seminars, training, and certification are all important options.

One outreach worker suggested a career path within the outreach role. "I think that an average worker who has been in the field in a growing agency should be able to move up to the position of senior outreach worker and supervise the other outreach workers. That's one way that the special qualities of outreach will not be lost. A lot of times outreach workers are living by the seat of their pants. [They need] someone who's been in the field and knows all the pitfalls, to be able to guide them."

According to some of the people interviewed, the most common career path—with the appropriate education—is from outreach worker, to case manager, to counselor to supervisor. Others mentioned upward moves into other areas of the field, like DUI programs, inpatient treatment, or rehabilitation. But some people interviewed seemed to have no clear sense of career mobility within the field.

When you picture yourself five years from now, what would you like your career to be?

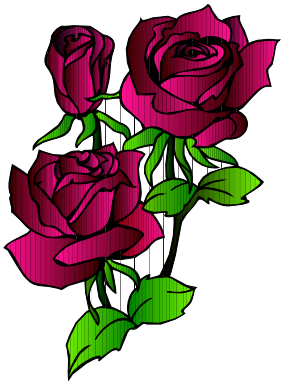
If you want to do that in five years, what will you need to do to get ready for it?

What resources (people, materials, schools, talents, inner strengths, etc.) will you need to call on in order to do those things?

What do you think are your greatest assets as an outreach worker, and as a human being?

What other qualities do you most want to develop in yourself, as a person and as an employee?

See the module on “Learning About Addiction and Recovery” for more information about professional development.



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A Developmental Model of Recovery *

By William White, in collaboration with Maya Hennessey,
Deborah Oberg and Diane Sonneville

While the original Project SAFE program manual published in 1988 raised a number of theoretical questions about the nature of addiction and recovery in women, there was insufficient data to fuel substantial theory-building. The Project SAFE experience is now long enough and rich enough to begin this process. The 1988 Program Manual, in calling for research to elucidate a developmental model of recovery for women involved with Project SAFE, noted that the appropriateness and timeliness of our service interventions hinged on knowledge in this critical area. In the continued absence of data that could be provided through long term outcome studies of women involved in Project SAFE, Project evaluators solicited stories and perceptions about stages in the recovery process for SAFE women from DCFS workers, outreach workers and treatment staff at all of the SAFE sites. An attempt was then made to organize this anecdotal material into a beginning conceptualization of the developmental stages shared by the majority of women in this project. This brief paper represents the first attempt to provide a theoretical framework from which 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 addict; the nature, intensity and duration of drug use; and the social milieu within recovery must occur.
- 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.

** This document first appeared as a resource paper included within the 1990 Project SAFE Program Handbook authored by William L. White, M.A. and published by the Illinois Department of Alcoholism and Substance Abuse (now the Office of Alcoholism and Substance Abuse-Illinois Department of Human Services) and the Illinois Department of Children and Family Services. The the entire Project SAFE report may be obtained by contacting either of these two agencies.*

- Treatment interventions appropriate to one stage of recovery may be ineffective or pose iatrogenic risks when utilized in another stage of recovery.

What follows is not a developmental model of recovery for women. The proposal of such a model would imply with arrogant oversimplification that substance abusing women constitute an homogenous group who 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 the social, economic and political oppression within which women are born and within which they must seek their destiny.

The Core of Shared Experiences and Adaptations

The developmental trajectory of addiction recovery is shaped by the totality of experiences each addict brings to treatment. Populations for whom similar life experiences have shaped core characteristics of personality share similar developmental processes of recovery. Project SAFE women were human elements in a complex web of interlocking relationships (and problems) spanning several generations. The women who entered Project SAFE over the past four years 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 characteristics which have been shaped by these experiences. It is our judgement that the core experiences most crucial to the developmental stages of recovery in SAFE women include the following:

- Early and continuing losses
- Parental pathology: High incidence of parental addiction and/or psychiatric illness
- Physical and sexual abuse
- Predatory social environments
- Recapitulation of family trauma in adult relationships

When clinicians within Project SAFE compared the experience of SAFE women with non-addicted women they had counseled who had not been involved in abuse or neglect of their children, significant differences emerged. Women from both groups reported sexual abuse in childhood, but Project SAFE women reported early age of onset of sexual abuse, a pattern of multiple rather than single perpetrators, a pattern of sustained (often measured in years) rather than single event abuse, and the presence of violence or the threat of violence as part of the pattern of abuse. What distinguishes Project SAFE women is not the fact of physical or sexual abuse or early childhood losses in their lives—events that many women may experience—but the severity of the physical and emotional trauma resulting from the intensity and duration of these experiences.

What Project SAFE clients tended to share was not only these conditions and events in their lives, but also, and perhaps more clinically significant, were the meanings which they attached to these experiences. The experiences catalogued above drove home deeply internalized messages about

oneself and the nature of the outside world. Some of these internalized messages become mottos for living. The nature and intensity of these mottos will influence the outcome of each client's involvement with addiction and with 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.

Within our patriarchal culture, 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 may be accused of somehow hurting their men, their children, their communities and their society. Acts of self-assertion may be viewed as acts of aggression, disloyalty and betrayal. While most women experience some aspects of this cultural double-bind, some women experience an intensified version of this self-dwarfing process due to generation-spanning problems in their families of origin. For the majority of women in Project SAFE, these family of origin experiences began what would become an escalating pattern of self-defeating dependency upon people and things outside the self.

Self-defeating patterns of dependency involve the following elements:

- 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. These self-defeating patterns of dependency are highly adaptive. Passivity can serve as a protective device as an alternative to challenge and confrontation with family or

cultural rules. Passivity and dependence often serve as homeostatic mechanisms within a marital/family system. Ego-sacrificing acts become ego-bolstering to others whether the other is in the role of parent, husband/paramour or therapist.

This dependency dimension influences the manner in which these women must be engaged in the change process (outreach and early treatment). Interventions that heighten guilt and inadequacy are misguided and harmful. The dependency dimension influences the changing role of the program (on-going treatment and aftercare) 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. The process is depicted as a movement from the denial and abuse of self to an affirmation of self within the context of mutually respectful relationships—intimate relationships, family relationships 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). For the years that followed, many counselors have 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. 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 the particular client. When a model doesn't fit the experience and needs of the client, its application results 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 substance abuse theory and technique to meet the needs of these special 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 ten years, we have seen six identifiable stages in the movement from addiction to stable recovery. These stages and the role 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. Early stage issues such as safety and trust don't completely dissipate; there on-going management simply requires less emotional effort—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 cocaine, alcohol and other psychoactive drugs which have interfered with many areas of life functioning. They exhibit a propensity to involve themselves in toxic relationships with abusive men and women. They also exhibit a propensity to involve themselves with social institutions, not to break these dependencies, but to sustain them over time. 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.

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 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 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, there 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 drug and the roles and relationships in the culture of addiction all held out the promise of pleasure and power but alas—as a metaphor for her life—brought 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 to sustain 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 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 abusing 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	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 Six 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 lighting 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, there 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—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 outline here. At the 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 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 came 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 failing 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 to 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 on 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. One is where one is because of persons, institutions (including DCFS) and circumstances over which the client had 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 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 a decision point during Stages 3 and 4 as to 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, 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 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 relationships, 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 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 inter-dependence. 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 only four years of experience with Project SAFE, we don't know a lot about this stage of recovery for SAFE women. From the earliest success stories within the project, we do have inklings of some of the elements within this stage. 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 getting employment.

- Working through tendency to substitute other excessive behaviors, e.g., workaholism, food, and sex
- A maturing out of the narcissistic preoccupation with self that characterized active addiction and early stage 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

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 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.

THE MANAGEMENT OF RESISTANCE IN THE TREATMENT OF ADDICTED WOMEN WITH HISTORIES OF CHILD NEGLECT/ABUSE THE PROJECT SAFE EXPERIENCE (1986-1996)

Resistance	Resistance is the totality of forces that inhibit change in the client.
Sources of Resistance	These forces can come from within the client (neurological deficits, prior victimization and abandonment), be exerted by the power of a drug over theclient (euph counter transference).
Types of Resistance	Resistance may be characterological, issue specific, relationship specific, or time specific.
Reality or Resistance?	What has often been called resistance in our clients is actually the reality of their daily lives that preclude consistent treatment engagement. These are addressed in Project SAFE through the provision of child care services, daily transportation and case management services designed to resolve problems that interfere with treatment.
Pain Threshold	The developmental trauma experienced by most Project SAFE clients produces an enormous capacity for pain and loss. As one outreach worker notes: "My clients don't hit bottom; my clients live on the bottom. To suggest that these clients aren't ready for treatment because they don't have enough pain in their life is the ultimate in clinical arrogance. They have more pain than most of us could comprehend. The issue is not a shortage of pain and consequences; the issue is an absence of HOPE."
Pain vs. Hope-based Interventions	Interventions that increase the client's experience of pain and consequences without simultaneously inciting hope increase suicidal ideation and destructive flight. Hope-based interventions rely on an enduring, consistent relationship in which the client is forced to re-evaluate herself and her relationship with the world. In Project SAFE, the first of these relationships is with an outreach worker.
Empowering vs. Enabling	Interventions that would have been historically labeled "rescuing" or "enabling" when applied to addicted men may be essential strategies in the engagement of significant numbers of addicted women. The purpose of these strategies is to engage and then disentangle the client from what has become a chronic cluster of hopelessness, learned helplessness, passivity andesteem-sapping dependence.

Focus on Doing	Given the pervasiveness of the dependency cluster, clients are unlikely to want to participate in all that is required to initiate a recovery process. The treatment focus is not on the desire but on the doing. It is our experience that changes in the external behavior evoke changes in the client's internal emotional architecture. Treatment slogans such as "Act as If," "Fake it Til You Make It," and "Just Do It!" all reinforce this principle. The motivation to initiate and sustain this early leap into doing comes from the coaching and cheerleading of staff.
Motivation and Treatment Outcome	Motivation or lack of motivation at the time of initial contact is not a predictor of treatment outcome. Some of Project SAFE's most successful clients were among the most resistant and treatment-hostile clients at initial contact.
Source & Timing of Motivation	Motivation for recovery for our clients is not a pre-condition for entrance into treatment but something that emerges out of the treatment process itself.
The Change Process	Very few of our clients experience "conversion reactions" through which they suddenly cast aside their drug relationship and addiction-shaped lifestyle. The change process is more evolutionary than revolutionary.
Developmental Stages	There are developmental stages of recovery just as there are developmenta lstages of addiction. There is an essential sequence to these stages: certain tasks must be completed BEFORE other tasks can be achieved. Some tasksare time-dependent. Treatment interventions must be measured for effectiveness according to their stage appropriateness.
Unfreezing	The acquisition of new perspectives/behaviors requires an unfreezing of current perspectives/behaviors. Unfreezing poses opportunity and threat. In this state, the client is free to move forward or regress backward. Transitions are a great opportunity for leaps of growth and for the threat of regression and relapse.
Safety	The capacity of the client to unfreeze current perspectives/behaviors and move into this area of opportunity and threat requires that we provide an environment of encouragement and physical and psychological safety.
Self-defeating Styles	Most Project SAFE clients bring chronic self-defeating styles of relating to professional helpers. These frozen, superficial styles must be shed or clientswill either self-destruct their treatment experience or passively "do treatment."

Testing and Ambivalence — Most Project SAFE clients go through a sustained period of testing before they fully involve themselves in a treatment and recovery process.

Pre-Treatment — Programs must have the capacity to tolerate and work through this process of testing. This stage of engagement we call "Pre-treatment." It is a stage of relationship building and treatment readiness that is designed to enhance safety and trust, reduce environmental obstacles to recovery, and incite motivation for personal change.

Treatment Techniques — Techniques that are successful in lowering resistance vary across developmental stages of recovery. Early techniques focus on accepting the client in her own environment, listening, self-disclosing, and encouraging. These are later expanded to include such techniques as self-assessment exercises, teaching, modeling, mentoring, humor, contracting, story construction and story telling.

Developmental Maturation — Staff have observed that many of the most successful clients went through three overlapping stages in treatment: 1) resistance, 2) regression and dependence, and 3) developmental maturation. The latter stages of maturation often parallel those of healthy child/ adolescent development. Concepts such as "surrogate family" and "reparenting" help describe the therapeutic dynamic within Project SAFE treatment sites.

Positive Resistance — The resistance to change that is an obstacle to early recovery becomes an ally and a primary means of relapse prevention in later recovery.

SEXUAL TRAUMA AND SUBSTANCE ABUSE
DEVELOPMENTAL TRAJECTORY AND IMPLICATIONS FOR TREATMENT
THE PROJECT SAFE EXPERIENCE (1986-1996)

Prevalence — Substance abusing women who have neglected or abused their children have a much higher frequency of childhood sexual abuse (45-95% of clients admitted across 19 treatment sites) than do women surveyed from the general population (16-34% range in most non-clinical surveys).

Clinical Vs. Non-clinical Populations — There are differences in the nature of the sexual abuse experiences of women in clinical populations (women receiving substance abuse, psychiatric, eating disorder, or domestic violence-related services) compared to women in the general population who report having been sexually abused in childhood.

Comparative Factors — The distinctive aspects of the sexual abuse experiences of women in Project SAFE include specific traumagenic factors and the absence of protective/resiliency factors.

Traumagenic Factors — The majority of Project SAFE clients experience childhood sexual abuse that is characterized by the following traumagenic factors:

1) early onset of abuse (pre-latency),
2) long duration of abuse (most frequently measured in years),
3) multiple perpetrators,
4) perpetrators from within the family or whose presence was sanctioned by the family,
5) violence or threat of violence as an aspect of the abuse experience,
6) more boundary-invasive forms of sexual abuse, and
7) disbelief or blaming as a response to breaking silence (with resulting continuation or escalation of abuse).

Protective/ Resiliency Factors — Most women in Project also lacked protective/resilency factors that could have prevented their victimization or could have provided nurturing and healing experiences that could have potentially mediated the long term effects of early victimization.

Role in Substance Abuse — Clinical staff working in Project SAFE often view the etiology of substance abuse as a process of self-medicating the sustained effects of emotional and

physical trauma.

Problem Multiplicity — Substance abuse rarely presents itself as a single, self-encapsulated problem in Project SAFE clients. Most SAFE clients present with a broad spectrumof problems that cross all the boundaries of our categorically segregated health and human service systems.

Role of Trauma in Neglect/ Abuse — It is the general view of Project SAFE staff that the SAFE client is higher risk for neglecting or abusing their own children NOT because of the FACT of their own developmental abuse but because of the INTENSITY AND DURATION OF TRAUMA reflected in that abuse. This risk is further increased by the absence of natural healing experiences--the absence of indigenous systems of support. The issue is as much what these clients didn't experience as what they did experience.

Asset-based Assessment — Much of what has been framed as the pathology of Project SAFE clients--impaired capacity for trust, manipulativeness, flight (early runaway behavior), disassociation--can be reframed in light of their early abuse as strategies of survival. The ability to discover strength and recognize one's capacity for survival was an important foundation in the recoveries of Project SAFE clients.

Intergenerational Transmission — Many of the problems of Project SAFE clients, including problems of substance abuse and physical/sexual abuse, seem to be moving in an inter-generationally pattern of self-accelerating intensity. There is great concern within Project SAFE about the need to break these intergenerational cycles of transmission.

Intergenerational Risk — The children of Project SAFE clients are viewed as being at increased risk of sexual abuse due to the following factors:

1) Some of the perpetrators who sexually abused Project SAFE clients also have access to their children.
2) The propensity of Project SAFE clients to become involved in intimate partners who have multiple problems creates an "at risk" environment for their children.
3) There is an increase in the number of SAFE clients who themselves report having been involved in the sexual abuse of others.
4) Decreased supervision of children of drug using parents may increase the children's exposure to a broad spectrum of victimizing behaviors.
5) Having rarely experienced boundaries of appropriateness and having not been protected, Project SAFE mothers may have difficulties teaching such

boundaries and affording such protection to their children.

6) 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 the mother's children.

Patterning

The developmental trauma experienced by Project SAFE client often results in sexualized relationships with men and strained, often competitive or hostile relationships with other women. Project SAFE women describe as almost compulsive their propensity for involvement in highly toxic intimate relationships. This pattern carries into recovery and poses a significant threat of relapse.

Immediacy of Threat

In addition to a history of early developmental violence, Project SAFE clients often are at increased risk of sexual exploitation and sexual assault in their later developmental years. Given this phenomenon of patterning, concern related to the immediate safety of project SAFE clients is a critical issue, particularly when these clients attemp to sever their involvement in these toxic relationships. Linkages with domestic violence resources is critical for Project SAFE sites.

Motivation for Treatment

The developmental trauma of project SAFE clients produces an enormous capacity for pain and loss. As one outreach worker noted, "my clients don't hit bottom, my clients live on the bottom!" As a result, hope-based interventions often prove more effective in initiating and sustaining treatment involvement than pain-based interventions.

Motivation or lack of motivation at the time of initial contact is not a predictor of treatment outcome. Some of Project Safe's most successful clients were among the most resistant and treatment-hostile clients at initial contact.

Addiction to Chaos

Chaos is an enduring theme in the lives of Project SAFE clients before and during the early stages of treatment. Adults survivors of sexual trauma learn how to use chaos (emergencies) strategically for emotional defocusing and intimacy management. Relentless relationship building and sustained case management is required to get through this "therapy in the middle of a hurricane" stage.

Excessive Behavior

When project SAFE clients stop using drugs and bring their daily life into greater tranquility and predictability, they are vulnerable for the development of new excessive behaviors that ranged from eating disorders to gambling problems.

Diagnosis

Many project SAFE clients come with prior histories of psychiatric diagnoses including from depression, anxiety disorder, and quite frequently borderline personality. Many staff prefer to reframe the characterological disturbances of SAFE

clients in terms of resilience rather than pathology. Viewing behaviors as temporally adaptive within a framework of traumatic stress disorder or Blume's "post-incest syndrome" proved more empowering and less stigmatizing than the more pejorative option of borderline personality.

Pre-Treatment

Clients with histories of developmental trauma require a longer period of time to engage in treatment. The earliest stages of engagement are marked by constant boundary and rule testing and by great ambivalence regarding treatment involvement. It is essential that programs have the capacity to tolerate and work through this testing period.

Developmental Stages of Recovery

Addressing childhood victimization for most Project SAFE clients continues in different ways through early, middle and late stages of addiction treatment. This is NOT an issue that can be postponed until late stages of recovery. At the same time, it is essential that each client remain in control of when, where, and to what degree of intensity this issue is addressed.

Some of the more common developmental stages in addressing sexual victimization include breaking silence about the victimization, sharing stories with other survivors, direct expression of anger to the perpetrator(s) (in some cases), linking sexual abuse experiences to other problem areas, identifying and self-correcting patterns of self-injury and self-sabotage, and reconstructing one's personal story and personal lifestyle.

Shame & Relapse

Shame (and its impact on self-esteem) is described as a core issue of treatment within project SAFE--an issue that often drives a wide spectrum of self-defeating and self-injuring behaviors. Clients are at high risk to relapse in response to intense experiences of success as they were to experiences of failure. Achievement of major milestones in treatment thus becomes a high risk time for relapse.

Iatrogenic Revictimization/ Boundary Surveillance

Clinical staff of Project SAFE recognize that there is a danger in revictimizing their clients at both ends of the intimacy continuum. The potential for abandonment and over-involvement with these clients is quite high. Monitoring the migration toward either end of this continuum is essential for all caregivers.

Interventions which violate the defense structure of the client through invasive and coercive attempts at eliciting behavioral change recapitulate historical victimization. Such interventions are more likely to trigger aggression or flight than positive behavioral change.

Safety

Great care has to be taken to assure the physical and psychological safety of Project SAFE clients within the treatment milieu.

Some clients have been so damaged (by male perpetrators) that they require a gender-exclusive environment in which to initiate their recovery.

In addition, some clients have been so traumatized in relationships of unequal power that they are more likely to initiate recovery in mutual aid groups or low intensity modalities within which the client has significant control over the degree and pace of emotional intimacy.

Clients did best in women's groups and in meetings filled with persons from the same geographical and cultural background. Clients did the least favorably in mutual support groups characterized by a weak "group conscience," e.g, sexualized rather than emotionally supportive relation-ships.

Victim Vs. Survivor

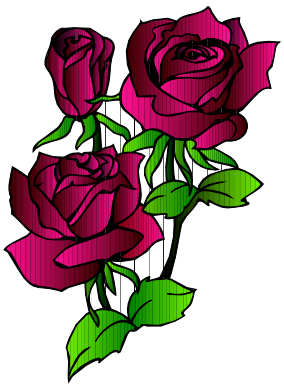
Most Project SAFE clients go through a "victim" stage in which their whole identity and life history is viewed in terms of the issue of victimization. Staff can learn to recognize and work through this stage rather than to try to avoid this stage.

Termination Problems

Project SAFE clients are hypersensitive to issues of loss and abandonment. Program "graduations" have to be carefully phased to avoid emotional regression and relapse. Anticipation of the end of treatment (and membership in the treatment community) and even anticipation of the end of DCFS involvement and the structure such involvement provides poses risks of relapse and have to be carefully managed.

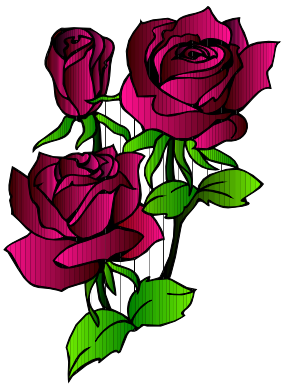
Duration of Treatment

The fact that most Project SAFE clients required longer periods of treatment than other clients to achieve and sustain sobriety, emotional stabilization and positive parent-child relationships was related to four inter-related factors: 1) gross developmental deficits, 2) a high number, variety and intensity of presenting problems, 3) significant environmental obstacles to recovery, and 4) an extended period of testing that preceded full treatment engagement.



THE DELIVERY AND SUPERVISION OF OUTREACH SERVICES

Part II:
The Supervision of Outreach Services



The Supervision of Outreach Services

Project SAFE

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1.0 Recruitment and Selection of Outreach Workers

Learning Objectives

1. Identify at least four qualifications essential to the delivery of effective outreach services to women in Project SAFE.
2. Describe four different sources for outreach worker recruitment.
3. Discuss methods of screening outreach worker candidates.
4. Discuss ethical and boundary issues that can arise in the hiring and supervision of recovering people working as outreach workers.

The Ideal Outreach Worker: Qualities, Experience, and Knowledge

Voices of Hope: An Orientation Manual for Outreach Workers includes a discussion of the kinds of knowledge, skills, and temperament it takes to function as an outreach worker serving addicted women and their families. In this section we'll try to focus our discussion on the kinds of qualifications that can be used to recruit and screen outreach worker candidates. Given your understanding of your project, the characteristics and needs of your clients, and the characteristics of other team members who will be working with the outreach worker, answer the following questions.

1. What do outreach workers need to know and understand? What understandings form the foundation for effective outreach services? What combination of education and life experience would indicate that a candidate has this understanding?

   _____

   _____

   _____

   _____

   Complete the checklist below with items from your discussion:

   ___ Knowledge of addiction and recovery

   ___ Knowledge of the special needs of addicted women

   ___ Knowledge of the local community—neighborhoods, resources, etc.

   ___ Knowledge of parenting/family life

   ___ Knowledge of abuse/neglect of children

   ___ Knowledge of community cultures

   ___ Knowledge of confidentiality requirements

   ___ _____

___ _____

___ _____

___ _____

Circle the four areas that you consider most important.

2. What do outreach workers need to be able to do? What skills must outreach workers have, and what tasks must they be able to perform?

_____

_____

_____

Complete the checklist below with items from your discussion.

___ Verbally persuade

___ Organize

___ Solve Problems

___ Listen

___ Advise

___ Write

___ Drive safely in spite of distractions

___ Make good decisions independently

___ Speak Spanish or _____

___ "Join" skills with client/family

___ Separate behavior from the person (not take the client's behavior personally)

___ Separate personal recovery from professional responsibility

___ _____

___ _____

Circle the four that you consider most important.

3. What do outreach workers need to be? What kind of person does it take to perform this role well over time?

_____

_____

_____

Complete the checklist below with items from your discussion.

___ Assertive

___ Patient

___ Tenacious

___ Naturally nurturing

___ Realistic

___ Reliable/dependable

___ Open-minded

___ Creative

___ Having a sense of humor

___ Fearless (in a smart way)

___ Determined

___ _____

___ _____

___ _____

___ _____

___ _____

Circle the four that you consider most important.

Where to Recruit Outreach Workers

Approaches to effective outreach worker recruitment vary from community to community and from agency to agency. In reviewing our experience in Illinois over the past decade, supervisors have identified the following methods as potential strategies for outreach worker recruitment. Check those that you currently use and circle those that could enhance your outreach worker recruitment efforts.

___ Recruiting from other programs within the agency

___ Recruiting outreach workers from the pool of successful agency clients

___ Recruiting through the AA/NA/CA and Al-Anon grapevine

___ Advertising through the local newspapers

___ Recruiting through local indigenous community leaders

___ Sending announcements of openings to other agencies that work with women

___ Recruiting through the local community colleges

___ Asking local ministers to help recruit potential outreach worker candidates from their congregations

___ Posting openings in local community centers

___ Recruiting from therapist applicants who don't have the experience/qualifications to be hired as therapists

___ Using the personal contacts of existing outreach workers and case managers

___ Using a volunteer program as a pool of people from which to develop and recruit potential outreach workers

___ _____

___ _____

___ _____

Screening Candidates

Some people who may be drawn to the role of outreach worker may not be appropriate for this role. They might lack adequate knowledge and skills, or they might have certain characteristics of temperament that make them unsuitable to work with addicted women. Based on your experience, what kinds of people would you try to screen **out** of the applicant pool? (Reflect on such issues as knowledge, personality, motivation, stability, and moral character.)

1. _____
2. _____
3. _____
4. _____
5. _____

Describe interview questions that help you identify candidates who would not be appropriate to work as outreach workers in your program.

1. _____
2. _____
3. _____
4. _____

Issues in the Recruitment and Supervision of Recovering People

There are a number of special issues that can arise in the recruitment and supervision of recovering people who are working as outreach workers. In the space below, we'll review a number of these issues.

A. Recruitment Issues

Mary, a former client who completed treatment four months ago, has applied for an open outreach worker's position. She did very well in treatment and has established what appears to be a solid program of continuing recovery. She has many skills that you're looking for in an outreach worker. She has a good basic understanding of addiction, treatment, and recovery. She knows the community well. She's highly motivated to work with addicted women and has above-average intelligence and excellent verbal skills. Your concern is that Mary has only seven months' sobriety at this point. What pitfalls might there be in hiring Mary as an outreach worker, given this short period of sobriety? What minimum length of sobriety do you believe is necessary for someone to work effectively as an outreach worker?

_____

_____

_____

_____

Sharine is a former client with two years' sobriety who has applied for an outreach worker's position. Like Mary in the above vignette, Sharine has many qualities that would make her an ideal outreach worker. Your concern about Sharine is whether her style of recovery is compatible with effective outreach work. Sharine is a "true believer" in the particular way she's maintaining her recovery, and is prone to excessive self-disclosure. While she has great passion for recovery and great motivation to work with other addicted women, what problems might her style pose in the role of an outreach worker? If Sharine were hired, how might these issues be addressed in supervision?

_____

_____

_____

_____

Addiction treatment agencies have been hiring recovering people for more than a century to work as part of interdisciplinary treatment teams. In screening recovering people for potential employment in the field, this question often arises: How do we assess whether a job candidate who presents as a recovering person has a stable and durable program of recovery? In addition to establishing and sticking to length-of-sobriety requirements, programs have found that they can often recognize recovering people with the strongest programs of recovery by the following:

- knowledge of recovery literature
- sponsorship (both having a sponsor and having sponsored others)
- past residence in a group home
- regular rituals of participation
- active application of the Steps

- a period of independent functioning separate from agency support (for former clients applying for outreach workers' positions)

Although these elements are based on people in Twelve-Step recovery, candidates who use alternative recovery pathways (for example, religion) can often be assessed for similar elements.

Observations from outreach workers and supervisors on the recruitment of recovering people to work as outreach workers included the following:

> *You need to find people who are naturally therapeutic and nurturing. The issue of whether a candidate is recovering is secondary.*
>
> *Recovering people bring some special capacities for empathy and understanding to their work, but it's important to realize they may also bring special vulnerabilities. Working as an outreach worker can bring back a lot of memories, and if you haven't dealt with some of the stuff your clients are going through, it can all come back and slap you in the face.*
>
> *I think those of us who are recovering have an inclination for over-involvement with clients because we know what the stakes of success and failure are. When you start crying all the time and all your thoughts and conversations are focused on clients, you're getting too attached. It's like we're working the program instead of them working the program.*
>
> [Recovering people working as outreach workers] *are going to face some threats to their recovery, so it's important that recovering people have a good deal of sobriety time and a good program of recovery. Sometimes you're walking into places filled with booze or cocaine—you're seeing it and smelling it. It can be risky for people who have only a fragile hold on their own sobriety.*
>
> *It's important to hire* [recovering] *people who understand that the client cannot recover exactly the same way that they did.*

B. Ethical and Boundary Issues

Chapter Four in *Voices of Hope* includes a general review of some of the ethical and boundary issues that can arise in the delivery of outreach services. After reviewing this material and reviewing the "AA Guidelines for AA Members Employed in the Alcoholism Field," complete the following two exercises.

There are special ethical and boundary issues that arise for recovering people working professionally in addiction treatment settings. Discuss with your outreach worker how she or he would evaluate each of the following activities using the following designations, and write the answers in the spaces below:

A=Always Okay
S=Sometimes Okay
N=Never Okay.

___ Agreeing to serve as an AA/NA/CA sponsor of a client currently in treatment

___ Sharing the fact of your recovery status with a client

___ Telling intimate details of "your story" to a client.

___ Agreeing to hear a client's Fifth Step

___ Attending AA/NA/CA meetings where current clients are present

___ Attending AA/NA/CA social functions where current clients are present

___ Transporting a client to an AA/NA/CA meeting or social function

___ Developing a personal friendship with a current/former client

___ Developing a sexual relationship with a current/former client

___ Developing a sexual relationship with someone from a current/former client's family or intimate social network

___ Disclosing your status as a recovering person in public settings

___ Disclosing your AA/NA/CA affiliation in public settings

Sometimes agencies can inadvertently contribute to the kind of role conflict that recovering people experience working professionally in addiction treatment settings. Comment on the following practices:

- Requiring AA/NA/CA attendance as part of one's job responsibilities
- Requiring participation with clients in AA/NA/CA functions as part of one's job responsibilities
- Announcing to visitors that two of your program staff are AA/NA/CA members
- Assigning a recovering staff person to serve as a liaison and resolve problems that arise with local AA/NA/CA groups
- Asking recovering staff members to share their stories in a public setting as part of their job responsibilities

What other practices have you seen that you thought contributed to the double-bind that recovering people sometimes experience working in addiction treatment settings?

_____

_____

_____

One of the most difficult situations any supervisor in addiction treatment can experience is the relapse of a recovering person who is working within his or her program. Consider the following scenario:

Alicia is a self-identified recovering person who has worked as an outreach

worker in your program for the past nine months. When she was hired she had three years' sobriety and prior employment as an outreach worker. You've noticed a number of changes in Alicia the past two months and have raised your concern about some of these changes in supervision. Alicia has consistently said that she's just going through a rough time right now but that she'll be fine. Following each of these discussions, her performance has improved for a period of time and then begun to deteriorate again. Today two of your staff tell you that they believe Alicia is using gain. Both have smelled alcohol on her in the past week. When you confront Alicia, she breaks down and confesses that she's been secretly drinking for the past month.

How would you respond to this situation? What supervisory options are available to you? If Alicia went to treatment, would she be allowed to continue as an outreach worker? How has your agency responded to situations like this?

_____

_____

_____

_____

Salary and Benefits: A Brief Comment

We asked all of those interviewed in the preparation of this manual about their views on the role of salary and benefits in recruiting and keeping outreach workers. Salary ranges for outreach workers (noted in the Spring of 1996 interviews) were between $14,000 and $20,000. There was a general consensus that the lower end of this range was inadequate and contributed to a high level of staff turnover among outreach workers. When asked which benefits were most important to recruiting and retaining good outreach workers, they generally agreed that financial support for continued education and potential for career advancement within the agency were the two benefits that outreach workers found most attractive.

Reading Resources

AA Guidelines for AA Members Employed in the Alcoholism Field. New York: Alcoholics Anonymous.

Bissell, L. And Royce, J. (1994). *Ethics for Addiction Professionals.* Center City, Minnesota: Hazelden.

White, W. (1993). *Critical Incidents: Ethical Issues in Substance Abuse Prevention and Treatment.* Bloomington, Illinois: Lighthouse Institute.

Working as, for or with Professionals. New York: Al-Anon Family Groups

2.0 Orientation, Training, and Professional Development

Learning Objectives

1. Describe three strategies for outreach worker orientation.
2. Discuss approaches to assessing the professional development needs of outreach workers.

Orientation Strategies

The orientation period for a newly hired outreach worker is important for many reasons. This period:

- begins the relationship between the supervisor and the outreach worker,
- ntegrates the outreach worker into the interdisciplinary team,
- sets the beginning structure for supervision, and
- initiates the outreach worker into her or his job responsibilities.

During the orientation period the outreach worker is grasping a basic understanding of program clients, and of the overall philosophy and operation of the treatment setting.

Some of the most frequently used methods or orientation for outreach workers include the following:

1. *Supervisory Coaching:* Most supervisors provide a formal orientation program for newly hired outreach workers, lasting from one to four weeks. During this period the outreach worker is oriented to her or his duties and given basic background information on addiction and its treatment. One option for the orientation of new workers is for the supervisor to use the Modules in *Voices of Hope: An Orientation Manual for Outreach Workers* as a vehicle of new employee orientation.

   Once the outreach worker begins to assume the job responsibilities, a daily review of assignments and daily debriefing of significant events can provide initial support and help solidify the relationship between the supervisor and the outreach worker. Supervisory contact is usually much more frequent during this orientation period than in the regular structure of supervision, which is discussed in a later module. Using other team members to provide part of this initial orientation and training can also be helpful in speeding the integration of the new worker into the team.

2. *Internal Mentoring:* One of the most effective methods of outreach worker orientation is to establish an internal mentoring program through which the newly hired outreach worker is paired with another, more seasoned outreach worker. In some programs, the new outreach worker accompanies the senior outreach worker for the first few weeks, until he or she becomes fully acclimated to the outreach worker's role and responsibilities. Internal mentoring is quite useful in light of the fact that outreach workers work so closely together. Internal mentorship programs can speed team building between outreach workers and minimize competition and conflict. Where an outreach worker is hired into an agency that has no one currently working in an outreach role, a program of external mentoring may be helpful.

3. *External Mentoring:* External mentoring is a process by which an outreach worker in one agency is linked with other outreach workers from one or more other agencies. This might be done by having senior outreach workers from other areas serve as temporary consultants to a newly hired outreach worker, or by having the newly hired outreach worker spend part of her or his orientation period working with an outreach worker from another agency whose philosophy of treatment or outreach is similar to that of the home agency. Where time and budget constraints prohibit this kind of staff exchange, telephone interviews of seasoned outreach workers by newly hired outreach workers provide an economical alternative. Another mode of external mentoring is providing opportunities for new outreach workers to network with their counterparts from other parts of the state in the periodic training conferences sponsored by DCFS and DASA.

What other methods of outreach worker orientation are used at your agency?

_____

_____

_____

_____

_____

Assessing Knowledge and Skill Deficits

It's possible to take the knowledge and skill areas discussed in the module on recruitment to create a format for the evaluation of an outreach worker's level of knowledge and skill development. It's important that this process be used, not as a source of criticism, but as a vehicle for personal and professional development. Checklists like the following can be used as self-assessment inventories that are then reviewed with the supervisor. A sample format for such a self-inventory is illustrated on the following page.

SAMPLE

Professional Self-Assessment Inventory

Before each of the knowledge and skill areas listed below, rate your current level of proficiency by placing one of the following letters: S=Strength; A=Adequate in this area; N=Need Training and Supervision in this area.

Knowledge Areas

___ history of addiction and its treatment
___ drugs of abuse/drug trends
___ the process and progression of addiction
___ gangs and the culture of addiction
___ HIV/AIDS
___ domestic violence
___ sexual abuse
___ needs of addicted women
___ substance abuse treatment modalities
___ special needs of addicted women
___ developmental stages of recovery in women
___ sobriety-based mutual-aid groups
___ mandatory reporting requirements related to neglect/abuse
___ ethical and boundary issues in service relationships
___ community resources
___ ethnic cultures
___ _____
___ _____
___ _____

Skill Areas

___ sensitivity to safety issues involved in transporting clients
___ assessing environments for safety threats
___ reducing and working through resistance
___ engaging and motivating clients
___ listening and communication skills
___ conducting home visits
___ crisis intervention and problem solving
___ resource identification and resource linkage
___ monitoring abuse/neglect issues
___ working with family members
___ assessing the needs of children
___ organizing activities and managing time
___ re-engaging clients
___ _____
___ _____
___ _____

Initial Professional Development Plan

The best way to prepare an initial professional development plan for an outreach worker is to focus on the following four questions in a meeting or series of meetings between the outreach worker and her or his supervisor:

1. What strengths of character, knowledge, and skill does the outreach worker currently possess?

2. What areas of character, knowledge, and skill need further development?

3. What are the outreach worker's personal and professional aspirations?

4. What internal and external resources can be used to enhance the professional development of this outreach worker?

The answers to the first two questions may differ according to the needs of each particular program, just as the answer to the last question will differ greatly by agency and by geographical area of the state. The identification of character, knowledge, and skill requirements in the last module can be used to create a format for professional development planning in meetings between the outreach worker and the supervisor.

Assessing Vulnerabilities of Temperament/Style[2]

One of the most difficult vulnerabilities to identify is not knowledge or skill deficiency, but a personality or interaction style that might undermine an outreach worker's effectiveness. Some of these kinds of problems might be enduring, or they might be temporary and intermittent—most often showing up during periods of high stress.

While the temporary signs of stress were addressed in the module on stress and self-care in *Voices of Hope*, the enduring personality/interaction styles can be addressed within the umbrella of personal/professional development. The following is an exercise that can be done with all staff, or in one-to-one supervision sessions that address these issues in a framework that ensures some degree of psychological safety.

[2] This exercise is adapted from a training activity developed by Steven Guerra.

Listed below are traits or values that outreach workers can show in their interactions with clients and co-workers:

Achievement	Honesty	Arrogance
Emotional Stability	Callousness	Leadership
Intelligence	Respect	Vision
Unpredictability	Calm	Passion
Spirituality	Compassion	Hopefulness
Insensitivity	Sloppiness	Cooperation
Religiousness	Pragmatism	Creativity
Risk-taking	Charisma	Dictatorship
Disorganization	Rigidity	Narcissism
Wisdom	Intuition	Friendliness
Rudeness	Motivation	Forgetfulness
Laziness	Carelessness	Self-righteousness
Flamboyancy	Slowness/Tardiness	Tendency to gossip
Disloyalty	Lack of realism	Common sense
_____	_____	_____
_____	_____	_____

List below the three traits/values you feel represent the strongest and most desirable traits of character that you bring to the workplace.

1. _____ _____
2. _____ _____
3. _____ _____

In the right-hand column, note any problems that could be created if each trait were carried to an extreme level. The point of this exercise is to discover ways in which even the best of traits can become problems when they're carried to an extreme. For example, confidence becomes arrogance, punctuality becomes compulsiveness, and achievement becomes workaholism.

From the same list, identify the three traits/values in other people that you most dislike.

1. _____ _____
2. _____ _____
3. _____ _____

In the right-hand column, see if you can identify any situation in which you exhibited the same traits. The purpose of this exercise is to explore how the things we most detest in others may be projections of unacceptable parts of our own character—parts that we might not be able to see in ourselves. What we hate can tell us as much about ourselves as what we love.

Team Building

Many people interviewed for insights into the supervision of outreach workers noted that a natural tension existed between outreach workers, people in other roles within the agency, and workers from other agencies who shared responsibility for service delivery with the outreach workers and therapists. They further noted that people in these roles worked together best when there were activities that brought them together to enhance their personal/professional relationships and their effectiveness as a team.
What kinds of activities might make it easier to integrate outreach workers into the agency team and into the broader community team that serves your clients?

1. _____ 3. _____

2. _____ 4. _____

Ongoing Professional Development Activities

For the past five years, Project SAFE evaluation reports have called for the "professionalization" (in the best sense of this term) of the role of outreach worker through the development of preparatory 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. Our focus here will be on the last of these recommendations.

One of the more fulfilling aspects of supervision is participating in the long-term development of supervisees. This involves two processes: creating career development options and starting a formal program of professional development planning. What career advancement options are available to outreach workers at your agency?

_____

What kinds of education, training, and work experiences are necessary to have these options?

_____

A formal program of professional development planning can be incorporated into your process of annual performance review, or it can be kept separate from the evaluation processes. The format on the following page is one that has proven helpful in guiding professional development planning meetings between the supervisor and outreach worker. After reviewing the format, note below how you might use this format or modify it for use within your agency.

_____

_____

_____

Professional Development Plan

Employee_____

Date Plan Finalized/Revised_____

Date Set for Next Review_____

1. My current strengths of character, knowledge, and skill (use the checklists from the last module and the last exercise to make it more specific):

2. Situations/responsibilities I find most difficult or fear that I might encounter:

3. Areas of character, knowledge, and skill that need further development (use checklists from the last module to make it more specific):

4. My personal and professional hopes and aspirations for the next five years:

5. Professional development resources that are accessible, affordable, and relevant to my needs:

6. My professional development plans for the next year are to:
   1. _____
   2. _____
   3. _____

3.0 The Supervision of Outreach Workers

Learning Objectives

1. Identify the obstacles most often encountered in supervision, and the skills that help you overcome those obstacles and deliver effective supervisory services.
2. Identify the structure and focus of your supervisory duties.
3. Identify the supervisory methods that are appropriate for your site.
4. Discuss the caseload management techniques that you employ.
5. Discuss a variety of boundary issues that sometimes arise in supervision.

Obstacles to Effective Supervision

There are many things that can interfere with the consistent delivery of effective supervision. In the space below, identify the obstacles you most frequently encounter in providing supervision to the outreach workers at your program.

_____ _____

_____ _____

_____ _____

Skills of an Effective Supervisor

Outreach workers across Illinois were asked to identify the most important skills and qualities needed for effective supervision of outreach services. Their responses fell into the following thirteen categories.

___1. Involvement: The ability to respect and support the outreach worker on a personal level without becoming intrusive.

___2. Flexibility: The capacity to alter the style and focus of supervision to meet the individual needs of each outreach worker.

___3. Modeling: The ability to teach by modeling appropriate attitudes and skills when relating to clients.

___4. Encouragement: The ability to convey optimism and faith in clients' capacity to change, and to convey the important role outreach workers can play in supporting that change.

___5. Direction: The ability to guide the outreach worker through the resolution of difficult situations.

___6. Patience: The ability to nurture the progressive maturation of the outreach worker's knowledge and skills through evaluation and teaching.

___7. Advocacy: The ability to represent the interests of the program and the needs of the

outreach workers, both within the agency and with outside funding and regulatory agencies.

___8. Courage: The ability to confront difficult issues that arise in staff-client and staff-staff relationships.

___9. Humor: The ability to laugh—at oneself, and within one's daily interactions with staff and clients.

__10. Communication: The ability to serve as a switchboard for information within the program, linking and coordinating people and activities.

__11. Technical Competence: The ability to bring to the program and its staff a high degree of clinical knowledge about the treatment of addicted women and their children.

__12. Self-Awareness: The recognition of one's own biases, deficiencies, and limitations.

__13. Accessability: Availability to respond to questions, provide direction, and help with problem solving.

Using this list, rate your current performance as a supervisor by placing the appropriate letter in front of each of the thirteen dimensions of supervisory effectiveness.

S= Personal Strength
A= Personal Adequacy
N= Area of Needed Development

Which of the above dimensions do you believe is most important to your further development?

_____

How might you go about strengthening this dimension of your role as a supervisor?

_____

_____

_____

The Structure of Supervision

Note the current structure you use in supervising outreach workers, by checking all of the following items that reflect regular supervisory activity.

___ One-to-one supervision: supervisor/outreach worker

___ One-to-one supervision: clinical staff or consultant/outreach worker

___ One-to-one supervision: outreach worker/outreach worker (tandem or peer)

___ Individual supervision: outreach worker/multiple supervisors (each supervisor focusing on different activities or different areas of skill development)

___ Group supervision: supervisor with outreach workers

___ Group supervision: supervisor with all agency team members

___ Group supervision: supervisor with workers from within and outside the agency.

___ Group supervision: outreach workers without supervisor ("peer/tandem supervision")

___ Group supervision: all team members without supervisor ("peer supervision")

___ Other _____

___ Other _____

Which of the above do you find most useful in supervising outreach workers? _____

_____

_____

Describe how the timing of supervision of outreach workers is structured in your program by checking all of the items below that are appropriate.

___ Time is consistently set for supervision and adhered to

___ Time set for supervision but often compromised

___ "PRN" supervision: "Let me know when you need me."

___ Supervision of assignments and debriefing of significant events occurs daily

___ Supervision of assignments and debriefing of significant events occurs weekly

___ Team meetings are held at least weekly

___ _____

___ _____

What changes, if any, would you like to make in the timing of supervision within your program?

_____

The Focus of Supervision

There are many aspects of, and many activities involved in, the supervision of outreach services. Check the activities below that currently take up the largest amount of your time:

___ Assigning cases

___ Reviewing daily activity assignments

___ Conducting case reviews

___ Internal problem solving

___ Reviewing documentation

___ Working with clients in conjunction with clinicians and outreach workers

___ Reviewing inter-agency relationships and issues

___ Addressing the personal problems of outreach workers

___ Monitoring travel—pick-ups, drop-offs, etc.

___ Educating/training

___ Other _____

___ Other _____

Many supervisors we interviewed stressed the importance of a high frequency of supervisory contact with outreach workers. The following is typical:

> *I maintain an open-door policy with my outreach workers, in addition to formal supervisory meetings. We are in a state of constant communication. I want outreach workers to be able to come and say, "This is what happened today—Did we do okay?" or "I'm not comfortable with what I said in this situation; how could I have said it differently?" Supervision is all of that give and take, not just what happens in our daily or weekly meetings.*

Supervisory Methods

Which of the following strategies or techniques of supervision would be appropriate for you and your setting? Check those that you currently use and place an X by those that you might consider using more often in the future.

___ Periodically riding with the outreach worker to pick up or drop off clients

___ Periodically going with the outreach worker on home visits

___ Doing formal case reviews with each outreach worker

___ Doing chart audits to monitor outreach worker documentation

___ Using a case presentation method in individual/team supervision

___ Using a critical-incident presentation method in individual/team supervision

___ Using an interdisciplinary case-planning conference

___ Using role playing in supervision

___ The use of reading assignments and discussion

___ Visits to other women's service programs

___ Clinical technique demonstrations

___ Use of audiotape or videotape

___ Other_____

___ Other_____

Caseload Management

The delivery of effective outreach services requires a particular chemistry in the relationship between the outreach worker and the client. Sometimes that chemistry can become quite toxic and severely undermine our ability to serve a particular client. Describe how you manage situations in which there appears to be a horrible mismatch between the elements that the client and the outreach worker bring to this relationship.

_____

_____

_____

Boundary Issues in Supervision

At times, complex issues can arise concerning the appropriateness of certain actions within the supervisor-supervisee relationship. In the space below are a number of vignettes illustrating various boundary issues in supervision. Comment on what you perceive to be the appropriateness or inappropriateness of the supervisor's action in each vignette.

> *Mary has been supervising outreach workers at her agency for three years. She and one of her outreach workers are involved in the same Twelve-Step recovery program. This outreach worker asks Mary to be her sponsor; Mary agrees because they have a good relationship, and the outreach worker has had difficulty making new relationships within the recovery community. How would you have responded if you were Mary? What problems might arise in this dual relationship between Mary and her outreach worker?*
>
> Comments and Observations:_____
>
> _____
>
> _____
>
> _____
>
> The following vignettes illustrate quite different approaches:
>
> - *Betty is an outreach worker supervisor who is all business. Her supervisory sessions are always task- and client-focused. Issues related to the personal lives of outreach workers never arise in supervision, even when such issues may be spilling over into and affecting service relationships.*
> - *Tanya supervises three outreach workers whom she knows very well. Whenever Tanya believes that an outreach worker's own emotional history might be interfering with her relationship with a particular client, or with her views on a particular clinical issue, she makes a point of mentioning this in individual supervision. She raises these kinds of questions for the outreach worker to reflect upon, as a way of improving her relationship with a particular client. Tanya never probes into these personal issues, nor would she allow supervisory time to*

be used to counsel the outreach worker on personal issues.

- *Rene, a third outreach worker supervisor, has quite a different style. She takes a maternal approach toward her outreach workers, is quite involved in issues related to their personal lives, and often offers advice related to their personal problems. There are many supervisory sessions in which more time is spent on the outreach worker's personal problems than on the problems of her clients.*

Compare and contrast these three approaches to boundary issues in supervision. Which styles could do potential harm to clients, to individual staff, and to the program?

Comments and Observations:_____

_____

_____

_____

_____

Marta supervises two outreach workers and three counselors. She regularly socializes with one of the outreach workers and one of the counselors. In fact, the three are almost inseparable away from work. How might these dual relationships affect Marta's relationships with the other team members? What kinds of problems might occur in these outside relationships that might interfere with Marta's effectiveness as a supervisor? What stance do you believe is most appropriate regarding a supervisor's outside-of-work relationships with those she supervises?

Comments and Observations:_____

_____

_____

_____

_____

Susan supervises three outreach workers and four counselors. Linda, one of the outreach workers, has told Susan that she may have to take some time off because her dad has been diagnosed with terminal cancer. A week later, one of the counselors approaches Susan and complains about Linda's recent habit of forgetting to return phone calls to DCFS. Susan tells the counselor that she'll talk to Linda about the problem, but asks the worker to give Linda some slack and support, because "Just between you and me, she's going through a really tough time right now. You see, her dad has been diagnosed with cancer." How would you have handled this situation? What issues are raised by Susan's disclosure of personal information about Linda drawn from the supervisory relationship?

Comments and Observations:_____

_____

_____

_____

_____

Joyce, a supervisor at a women's addiction treatment program, goes to a comedy club on a visit to a neighboring city. In the middle of the performance she looks across the room and sees one of her outreach workers, a self-described "recovered alcoholic," drinking alcohol. If you were Joyce, how would you respond to this situation? Is the drinking behavior of a self-proclaimed recovered alcoholic on Saturday night a gross violation of professional conduct or a non-work-related behavior that is none of the agency's business? There has been no deterioration in this worker's job performance. If you were going to confront the worker about this outside-of-work behavior, what agency or professional standard would you use as the basis of your confrontation?

Comments and Observations:_____

_____

_____

_____

_____

Reading Resources:

Broadwell, M. (1984). *The New Supervisor.* Reading, MA: Addison-Wesley Publishing Company.

Powell, D. (1980). *Clinical Supervision: Skills for Substance Abuse Counselors.* New York: Human Science Press.

Wilson, L. (1981). *Field Instruction Techniques for Supervisors.* New York: The Free Press.

4.0 Enhancing the Safety of Outreach Workers

Learning Objectives

1. Discuss at least four strategies for enhancing the safety of outreach workers in the field and the safety of clients and staff at the service site.
2. Identify at least six clinical risk factors that increase the likelihood of violent aggression.

The Importance of Safety Issues in Outreach

Safety is an essential issue within women's service programs in Illinois. During the past decade:

- Outreach workers have lost clients to murder.
- Outreach workers and clients alike have been caught in the crossfire of gang violence.
- Angry paramours have stalked clients to the service offices.
- Gang members and drug dealers have approached outreach workers demanding to know who they are.
- Clients have made verbal threats toward outreach workers.
- Clients have carried weapons with them to the agency.
- Disgruntled ex-employees have made threats toward agencies in which outreach workers were employed.
- Outreach workers have walked into situations of domestic violence while conducting home visits.

Physical and psychological safety is an important issue for the women and children we serve, and for all involved in the service-delivery process.

Hiring and Orientation

In the space below, identify at least four factors that you might consider in the hiring and initial orientation of outreach workers, in order to enhance the effectiveness and safety of outreach workers in the field.

1. _____
2. _____
3. _____
4. _____

Target Hardening: Reducing Personal Vulnerability

"Target Hardening" is a strategy used by neighborhoods and institutions to lower their vulnerability to violent attack. For example, target-hardening strategies in a violence-plagued school might include the use of metal detectors at all entrances, the employment of security guards, the use of parent volunteers along school routes and on the school grounds at the beginning and end of the school day, and release times staggered by age or grade level. In the following exercise, you'll apply this concept of target hardening to your own service office.

Consider your office to be the target of a disgruntled, potentially violent client or ex-client, or the target of a violent paramour whose partner has just told him by phone that she's leaving him. Walk through your facility with this situation in mind and answer the following two questions:

1. What aspects of this environment would enhance the safety of staff and clients?

   _____

   _____

   _____

2. What aspects of this environment fail to protect clients and staff adequately?

   _____

   _____

   _____

List two things you can do to increase the safety of your service site:

1. _____
2. _____

The concept of target hardening can also apply to individuals who work in the field. Describe what advice you might give to your outreach workers related to the following:

Personal dress_____

Color of outer clothing_____

Hats_____

Jewelry_____

Carrying money/valuables_____

Eye contact_____

Vehicles_____

_

Attitude_____

Surveillance of the environment_____

Working in pairs_____

Instincts_____

General Strategies of Safety Enhancement

Rate the use or possible use of the following strategies in your program, using the following symbols:

C=Currently using

P=Would have potential at our program/will consider using

W=wouldn't work or wouldn't be possible at our site

___ Orienting all outreach workers to high-risk areas of communities being served

___ Conducting safety-related training for outreach workers

___ Maintaining liaison with local police department and security forces, such as security staff in public housing complexes

___ Equipping outreach workers with cellular phones

___ Equipping outreach workers with beepers

___ Rating neighborhoods or particular locations as low, moderate, or high risk

___ Conducting some "home visits" in the agency van or car, rather than in the client's home

___ Teaming two outreach workers together to conduct home visits in neighborhoods or sites rated as high risk

___ Establishing specific safety guidelines for conduct within the van or car

___ Offering self-defense classes for outreach workers

___ Scheduling home visits at lower-risk time periods (for example, morning rather than late afternoon or evening)

___ _____

___ _____

___ _____

___ _____

Critical Incident Training

Critical incident training is a case-study approach to building a worker's understanding and problem-solving skills. The training provides a safe environment in which in which one can think through all of the options in responding to a potentially difficult situation. The following situations are samples of critical incidents that might be used for inservice training of staff. Trainees should be asked to read each of the situation descriptions, then answer the following questions:

1. Would you rate this situation as a low, moderate, or high risk to your safety? If the information is inadequate, what else would you need to know in order to assess your risk?
2. What possible courses of action might you take? How would you handle this situation?
3. What standards (ground rules, advice) might guide other staff who found themselves in a similar situation?

Situation #1: *You are in the field conducting home visits. The client you're going to see lives in a building with a large number of apartments. There are often many men drinking in the parking lot or the building's porch, but today there are only two elderly men talking to one another. However, as you approach the apartment of your client, you hear very loud voices from inside the apartment. You recognize the voices as those of your client and her paramour. You can tell from the sounds coming from within that they're involved in a fight that is both verbal and physical, and of great intensity.*

Risk: ___Low ___Moderate ___High

Possible Courses of Action:_____

_____

_____

Standards to guide staff:_____

_____

_____

Situation #2: *You're approaching a housing complex to pick up a client who is sometimes a little slow leaving the building. Two young men you are sure are drug dealers (you've watched their activities before while you were waiting in front of the building) approach the van and ask you who you are.*

Risk: ___Low ___Moderate ___High

Possible Courses of Action:_____

_____

_____

Standards to guide staff:_____

_____

_____

Situation #3: *You enter a neighborhood that you've been through many times, but today there seem to be a very large number of people on the streets, many of whom seem to have been drinking. You also notice that most of the elderly people and children you usually see in this neighborhood are not on the streets today. The neighborhood seems louder than usual, and there's a sense of something in the air, but you can't exactly identify what it is.*

Risk: ___Low ___Moderate ___High

Possible Courses of Action:_____

_____

_____

Standards to guide staff:_____

_____

_____

Situation #4: *You enter a high-rise building to visit a client who lives on the 11th floor. You discover that only one elevator is working, and that it only goes to the eighth floor.*

Risk: ___Low ___Moderate ___High

Possible Courses of Action:_____

_____

_____

Standards to guide staff:_____

_____

_____

Situation #5: *You have a client who has been involved in a very violent relationship. As she's progressed in treatment, she's spent more and more time talking about her feeling that she needs to get out of this relationship if she's ever going to get into recovery. During the past three weeks, at her request, you've helped her move out of her apartment to a shelter. You've also helped her contact a domestic violence program, which helped her get an order of protection against the paramour. Today the paramour accosted you in the agency parking lot and accused you of poisoning the client's mind. He threatened that if you didn't stop "messing with her," he was going to "teach both of you a lesson."*

Risk: ___Low ___Moderate ___High

Possible Courses of Action:_____

_____

_____

Standards to guide staff:_____

_____

_____

Situation #6: *All week, conflict has been building between two of your clients. The only open seats in the van are two together in back. The first client to be picked up takes one of these seats, and as soon as the second client is picked up, the two start in on each other and the tension rapidly rises.*

Risk: ___Low ___Moderate ___High

Possible Courses of Action:_____

_____

_____

Standards to guide staff:_____

_____

_____

Situation #7: *During a home visit to a client who hasn't been to treatment in a week, you notice that her three-year-old child is heavily bruised, that the house is in a shambles, and that there appears to be no food for either the mother or the child. You tell the client that you're legally and ethically bound to notify DCFS about these conditions.*

Risk: ___Low ___Moderate ___High

Possible Courses of Action:_____

_____

_____

Standards to guide staff:_____

_____

_____

Situation #8: *You're transporting clients from their homes to the treatment center. You remind the last client you pick up to put on her seat belt. She verbally explodes, accusing you of always picking on her while you let the other women get away with murder. She says that you've never liked her and that you'd be happy if she "screwed up" in treatment and couldn't get her baby back. You're taken aback because this client is usually of mellow temperament and you seemed to have had a good relationship with her until now.*

Risk: ___Low ___Moderate ___High

Possible Courses of Action:_____

_____

_____

Standards to guide staff:_____

_____

_____

Assessing and Predicting the Risk of Violence by Clients

Situations sometimes arise in which an outreach worker believes that a client poses a significant threat to another person or persons. When these incidents are brought into supervision, you face difficult clinical, ethical, and legal issues in trying to assess the risk and take steps to reduce the threat. Listed below are some of the risk factors that have been associated with acts of violence against others committed by people with histories of substance abuse. A review of these factors can help you determine the degree of imminent risk. (Note: The same factors can be applied to a paramour or another person in the client's life, to determine the immediate risk from that person.)

___ The client has experienced abandonment, brutalization (severe physical abuse), and horrification (watching others be abused). These acts began early, happened over a long period of time, and/or were perpetrated by more than one person.

___ The client has some history of setting fires, cruelty to animals, and bed-wetting in childhood.

___ The client has a past history of aggressive and violent behavior

___ The client has a substance-related organic disorder that is lowering her level of mental functioning.

___ The client has been diagnosed with, or presents symptoms of, a serious psychiatric illness that is associated with increased risk of violence.

___ The client is currently experiencing paranoia, delusions of persecution and ideas that, if acted out, might result in violence.

___ The client is very immature, has low self-esteem, is very impulsive, and engages in risk-taking behavior.

___ The client is jealous, controlling, and hypersensitive to rejection.

___ The client talks about her fears of "blowing up" or losing control.

___ The client has no social supports, or has social supports that encourage aggression.

___ The client has no personal values strong enough to curb her violent urges.

___ The client has made a specific threat toward an identified person.

___ The client has guns or other weapons, or has access to them.

Source*:* White, W. (1996). *Aggression Severity Index*. Bloomington, IL: Lighthouse Institute.

Critical Incident Debriefing

In some cases the violence that your staff is exposed to in the course of their work might have long-lasting psychological effects on them. These effects can include intrusive memories of the violent event, heightened fear and anxiety, shame about their response to the incident, a tendency to avoid people or things that they associate with the event, and/or psychic numbing.

A critical incident debriefing can help staff work through the effects of a violent incident and avoid sustained psychological effects. The debriefing is a scheduled, structured discussion about a stressful or traumatic event that is outside the range of normal experience. Anyone who was exposed to the traumatic incident has the option to attend. The meeting, which usually lasts no longer than two hours, can be facilitated by an outside trauma specialist or by a supervisor. It's usually held within 24-72 hours after the event. The critical incident debriefing is **not** counseling, nor is it a substitute for counseling.

The format of the critical incident debriefing meeting is as follows:

- Introduction and the explanation of ground-rules
- Cognitive questioning about group members' involvement in the critical incident
- Movement from facts to thoughts and feelings about the event
- A factual reconstruction of what happened. The participants are told:
  Describe what happened from your point of view.
- The experience of emotional catharsis in response to the question:
  What was the most difficult aspect of this situation for you personally?
- The occurrence of "personal sense-making," initiated by the question:
  What thoughts or reactions have you had since the incident?
- The experience of a prediction-and-education phase, introduced by the facilitator's statement:
  These are some things you might experience over the next several days and weeks.
- Closure and linkage to follow-up resources, e.g., an EAP.

If a violent incident occurred today involving one or more of your outreach workers, what resources would be available to you to help conduct a critical incident debriefing of these workers?

_____

_____

_____

Reading Resources:

Friedman, R., Framer, M., and Shearer, D. (1988). Early Response to Posttraumatic Stress. *EAP Digest*, September-October.

Howells, K. And Hollin, C., Eds. (1989). *Clinical Approaches to Violence.* New York: John

Wiley & Sons.

Roth, L. Ed. (1987). *Clinical Treatment of the Violent Person.* New York: Guilford.

Stennett-Brewer, L. (1994). *Violence in the Workplace: Risk Reduction and Management.* Bloomington, IL: Lighthouse Institute.

5.0 Managing the Stress of Outreach Work: Supervisory Strategies

Learning Objectives

1. Identify at least three early warning signs of excessive stress.
2. Identify and define at least five role stressors that lead to stress-related deterioration in professional performance.
3. Identify at least three strategies for managing individual and team stress.

Recognizing Stress-Related Problems in Individuals and Teams

The module on stress management in *Voices of Hope: An Orientation Manual for Outreach Workers* identified personal indicators of stress in five categories: health, excessive behavior, emotional, relationship, and attitude indicators. Drawing from the indicators identified under those five categories**,** complete the following exercise.

Select two staff members whom you supervise. In the space below, identify indicators that tell you whether each person is at a subtle, moderate, or excessive level of stress.

NAME:	**NAME:**
Subtle Indicators:	Subtle Indicators:
Moderate Indicators:	Moderate Indicators:
Excessive Indicators:	Excessive Indicators:

Team indicators of excessive stress can include frequent tardiness and absenteeism, conflict between individuals or roles within the team, scapegoating of individual staff or units, grievances, staff turnover, client complaints, and decreased quantity and quality of services. On the scale at the top of the following page, draw a line that indicates the levels of stress within your work unit over the past year.

Levels of Stress in the Work Unit

High----------

Mod----------

Low----------

Jan Feb Mar Apr May Jun Jul Aug Sep Oct Nov Dec

Which team stress indicators (from the previous page) are reflected in the high and low levels that you've plotted?

High _____

_____

Low _____

_____

A Model for Strategy Development

The diagram below shows the interaction among three factors: role stressors in the work environment, role supports in the work environment, and the individual preferred defense structure (PDS) of an outreach worker.

Role Stressors

Role stressors are conditions in the work environment that simultaneously decrease one's ability to do his or her job, and threaten one's safety and comfort. Role supports are conditions that increase one's ability to do her or his job and increase personal comfort and loyalty toward the organization. The PDS is the unique style of responding to stress and change that each outreach worker has developed over a lifetime.

Listed below are some of the most common role stressors experienced by health and human service workers:

- *Role/Person Mismatch* is the incongruity between an individual's knowledge, skills, and temperament and the kind of knowledge, skills, and temperament required to fulfill the role effectively.
- *Role Conflict* is the experience of contradictory demands from two or more simultaneously held roles.
- *Role/Integrity Conflict* is a conflict between one's personal values and the values encountered in the performance of one's job.
- *Role Ambiguity* is the experience of inadequate knowledge about one's role responsibilities, task priorities, and line of accountability. (What is my job? What tasks are most important? Who do I report to?)
- *Inadequate Role Feedback* is the lack of information on the adequacy of role

performance and methods of improving performance.

- *Role Overload* is caused by excessive and unrealistic expectations regarding the quantity and quality of work to be completed within a particular time-frame.
- *Role Safety Problems* create apprehension about one's physical and psychological safety during the performance of one's job.
- *Role Security Problems* are associated with the experience of uncertainty about one's future role in the agency.
- *Role Connectedness Problems* stem from a worker's isolation from, or overconnectedness to, other members of the organization.
- *Role Deprivation* is the sudden or gradual removal of all significant responsibilities from a worker (retirement on the job).

If your outreach workers were surveyed today, which three role stressors from the above list would they report experiencing most frequently and most intensely? Identify these on the lines below.

1. _____
2. _____
3. _____

Role Supports

Common types of role supports include timeout periods, access to training, supervisory encouragement, peer recognition, time flexibility, pleasant physical conditions, adequate equipment and supplies, and group camaraderie. Review the definition of role supports on the previous page, and list as many supports as you can that now exist in your work environment.

_____ _____

_____ _____

_____ _____

_____ _____

Responding to Role Stressors

You are the supervisor of a women's treatment unit. Because of a variety of funding cuts and staff turnover, the staff of your unit have been working under a condition of overload for the past four to five months. You have just been informed by your agency director that an accreditation site visit will occur within 90 days and that your unit will receive special scrutiny, since it hasn't been surveyed during previous site visits. Within the next 90 days you must write and implement a number of new policies and procedures, while continuing at your current service level. Meeting this deadline will require some of your therapists' time to write the new policies, and will also place additional responsibilities

on your outreach workers over the next 90 days. You have serious concerns about what this challenge will mean to your already overloaded unit. You also have particular concerns about what these extra demands will do to one of your outreach workers, who already is exhibiting symptoms of excessive stress.

1. What strategies might serve to reduce role stressors (reduce the total amount of work that needs to be performed) during this 90 days?

_____

_____

_____

_____

2. What strategies might serve to increase supports for your unit during this 90 days?

_____

_____

_____

3. Describe what you would consider the ideal leadership style for this 90 days?

_____

_____

_____

_____

4. What strategies might be used to support the physical and emotional health of the team as a whole, and of the particularly vulnerable outreach worker, during this 90 days?

_____

_____

_____

_____

5. The work was successfully completed and the site visit went very well. Describe how you would handle the two to three weeks following the site visit.

_____

_____

_____

_____

This exercise reinforces three basic strategies that supervisors have used in managing work unit stress:

1. The supervisors can diagnose the unique stressors experienced by a worker or a team, then manipulate the environment to reduce these conditions to the greatest extent possible. Many role stressors will be caused by factors outside the work unit and not be in the immediate control of the supervisor.
2. The supervisor can examine the existing supports experienced by a worker or a team, then manipulate the environment to increase supports that help the worker or the team sustain themselves in the face of those stressors. It is usually easier to increase role supports than it is to eliminate role stressors.
3. The supervisor can intervene programmatically (e.g., by implementing an employee assistance program) or individually (e.g., by providing personal support to a worker) in order to support the strength and flexibility of each worker's PDS.

General Strategies for Managing Individual/Team Stress

In the space below, describe some strategies for managing stress within your work unit in general, and for your outreach workers in particular.

1._____

2._____

3._____

4._____

5._____

Here are some of the approaches that other supervisors have used to manage the stress experienced by outreach workers:

- Flexible use of mental health days (both formal and informal)
- Reinforcing realistic expectations for treatment outcome by defining expectations in small, discrete units for each client
- Teaming for the most difficult home visits
- Using training as a reward and a time-out period
- Brief team meetings at the beginning of the day to organize the day, and at the end of day for emotional debriefing
- Impromptu supervisory sessions when it appears that an outreach worker is having difficulty
- Arranging for recognition of outreach workers by program/agency directors or by funding agencies
- Periodic retreats where staff can step back and critique program operations and reconnect

personally as a team

- Using outside clinical consultants to help process the most difficult situations being faced
- Using supervision to identify the kinds of environmental (agency/inter-agency) obstacles that get in the way of effective outreach services
- Acknowledging the work of outreach workers, both verbally and in written commendations to be placed in their personnel files

Reading Resources

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6.0 A Final Note

Notwithstanding the knowledge and skills which outreach workers and their supervisors have gained over the past decade, we are all still learning, and, hopefully, continuing to acquire and practice new methods of using outreach services to reach high-risk, treatment-resistent women. Neither the authors of this manual, the Illinois Department of Human Services, Office of Alcoholism and Substance Abuse (the Illinois Department of Alcoholism and Substance Abuse when this manual was written) , nor the many others who have contributed to the completion of this work pretend to have "all the answers" when it comes to providing and supervising outreach services. As time goes on, some of the skills and practices described within these pages will undoubtedly change or undergo modification. Comments concerning the material in this manual are both welcome and encouraged.



Selected Papers of William L. White

www.williamwhitepapers.com

Collected papers, interviews, video presentations, photos, and archival documents on the history of addiction treatment and recovery in America.

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Substance Use Trends: History and Principles

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Maybe if we listened, history wouldn't keep repeating itself. ~ Lily Tomlin

As two (or too-) long-tenured addiction specialists with interests in history and psychopharmacology, we are frequently asked to talk about the history and future of substance use. The opening of a new century seemed a fitting time for us to articulate a few of the principles that underlie the seemingly inexplicable pendulum swings and cycles that pervade the history of drug use in America. Our hope is that this discussion will help addiction professionals understand and anticipate such trends within their local communities.

Specification Principles

Perhaps a beginning point is to acknowledge what have been called specification principles. All drug-person interactions are potentially idiosyncratic. The potential effects and risks of a drug cannot be generalized without first specifying the characteristics of the drug (e.g., purity, dosage, method of administration), the characteristics of the potential drug consumer (e.g., age, gender, medical condition, motivations and expectations), and the physical and social environment in which the drug-person interaction will take place. The most significant drug trends of the past two centuries have involved shifts in these areas of specification: new drugs, new forms of old drugs, heightened drug potency, more efficient methods of drug administration, use of multiple drugs in high risk combinations and sequences, lowered age of onset of regular drug use, and use of drugs in high risk contexts that threaten public safety. The lesson we can take from this is a simple one: any change in a drug, the characteristics of drug consumers, or the context of a drug's use may require a radical re-evaluation of what we know about the drug and its potential harm.

Dormancy, Hibernation and Generational Learning

A drug can lie dormant within a culture for generations before it breaks into the open as a favored intoxicant. Opium, cannabis, cocaine, amphetamines, barbiturates, and LSD are among the drugs that had a long dormancy period before

being widely misused. This principle suggests that many of the drugs whose misuse will capture our future attention are already here, but we do not see them. Once a drug emerges, it may move through a stage of popularity, decline and extended hibernation, only to re-emerge again, usually in a more virulent form. This hibernation process creates the cyclical re-appearance of certain drugs.

Some drug epidemics are inherently self-limiting, meaning that the prospects of collective experimentation progressively decrease via the accumulation of drug-related consequences, diminishing rewards, and boredom with the experience. Such patterns burn themselves out through a process of intra-generational learning. However, there is no historical evidence of intergenerational learning. Drug trends cycle, in part, because each generation is replaced by a new generation who arrives with no collective memory of drug casualties but a deep belief in their own unique invulnerability. Historically, we are forced to conclude that each generation must accumulate its own sacrifices and learn its own lessons on the pyres of drug experimentation. As a result, some drug trends in America's past can be expected to resurface again among future generations.

Drug Sequencing

Most drug epidemics don't simply disappear: they transform themselves into something else. For example, periods of excessive stimulant use are often followed by periods of rising alcohol, sedative and opiate use. There are drug-facilitated cycles of stimulation, introspection, intoxication, and emotional anesthesia. Repeated episodes of each drug experience generate the appetite for the next experience/drug in the sequence. In the second half of the twentieth century, we have seen two repetitions of the following cycle: short acting stimulant use (cocaine) followed by longer acting stimulant use (methamphetamine) followed by a rise in depressant use (alcohol/sedatives/heroin). While this cyclical pattern of stimulation, over-stimulation, self-sedation is evident in individuals, it is equally evident in the evolving drug tastes of the larger society. The implication is that a community plagued by rampant methamphetamine dependence must respond not only to this pattern, but to the rising problems of alcohol, sedative and narcotic dependence that are likely to follow it.

Drug-Culture Fit

Some drugs, such as alcohol and nicotine, have penetrated nearly every culture. This suggests that the pharmacology of certain drugs can serve different functions for different people, serve different functions for the same people at different times in their lives, and serve evolving functions within cultures as a whole. The celebration and suppression of drugs can also reflect continuities and discontinuities between the pharmacological effects of various drugs and the evolving temperament and values of a culture. This helps explain why the same drug can be revered in one culture and abhorred in another. A shift in a culture's drug choices often reflects a shift in cultural values. Aggregate drug appetites reflect a communal hunger for certain kinds of experiencesBa physical, psychological and cultural fit between a drug and its consumers. The "fit" tells us something about the drug, the temperament of a people, and the evolving culture. One could easily make the case that marihuana use in the 1960s and cocaine use in the 1980s marked a perfect fit between cultural temperament and pharmacological effects.

While the rising popularity of some drugs taps deep needs within a large portion of the culture, other drugs meet those needs for only a distinct subpopulation. Understanding such niched drug use is only possible through an understanding of the experience and world view of those drawn to the drug.

Technology and Drug Trends

Technological innovation can increase or decrease drug use and its consequences. Technologies that have increased drug consumption and its consequences include a long list of processes (e.g., distillation, isolation of plant alkaloids, drug synthesis) and products (e.g., the pipe, the safety match, machine-rolled cigarettes). Technologies that have lowered drug use and its consequences include alternatives to such substance, such as safe and socially acceptable non-alcoholic beverages that followed water purification, pasteurization, and refrigeration and chemical processes that created non-narcotic painkillers and non-barbiturate sedatives.

The hypodermic syringe offers an interesting case study. This new instrument arrived with the promise to reduce morphine addiction by requiring smaller amounts of morphine via injection compared to oral use. But this new technological innovation turned out to be a Trojan horse. In a similar manner, nearly every substance today recognized as a "drug of abuse" began its career as a medical remedy, including a remedy for addiction. A history in which opium, morphine, heroin, chloral hydrate, barbiturates, cocaine, amphetamines, tranquilizers, LSD, and cannabis have all been used in the treatment of addiction begs for caution, skepticism and sustained monitoring of every new psychoactive drug introduced into medicine.

Principle of Initial Vulnerability

Those individuals closest to the discovery or application of a psychoactive drug are particularly vulnerable to untoward consequences resulting from its use. Those close to such discoveries often become victims of the new technology before its full power is understood. A few 19th century examples illustrate this principle: the overdose death of the wife of Dr. Alexander wood, inventor of the hypodermic syringe; the cocaine addiction of Sigmund Freud's colleague, Dr. Ernst von Fleischl; the addiction of Dr. Horace Wells to chloroform following his introduction of nitrous oxide into dentistry; and Dr. William Halstead's (the father of American surgery) addiction to cocaine and morphine. More recent examples include the addiction of anesthesiologists and nurse anesthetists to fentanyl following its introduction as a narcotic anesthetic.

Risk Perception

Many things can influence the relative popularity of a particular drug: its degree of availability, its price, its cultural status, its pharmacological effect, and its perceived risks. Drug experimentation decisions are often influenced by the ratio between the perceived benefits of the drug in relationship to its perceived risks. Drugs can be consumed because of their perceived low-moderate risks, in spite of their high risks, or because of their high risks. Changes in behavior are often preceded by changes in perceptions and beliefs regarding risks and benefits.

The Red Herring

The use of exotic and illicit drugs that garner great public attention may mask fundamental changes that are occurring in the use of socially approved drugs. When the history of the 1960s and early 1970s is fully understood, the issue of illicit drug use will pale in comparison to radical changes that were occurring in the use of alcohol, tobacco and other licit psychoactive drugs. Illicit drug use stood as a red herring that hid the lowering of the legal drinking age; an unprecedented promotion of alcohol and tobacco to young people, women and people of color; and the promotion of prescription psychoactive drugs to a mainstream America concerned about the growing "drug problem."

Manufactured "Epidemics"

Rhetorical amplification of slight shifts in drug use into claimed Aepidemics@ are often fueled by personal and institutional

self-interest. Multiple parties reap rewards in the face of a perceived drug epidemic: self-proclaimed experts and stakeholders (law enforcement and criminal justice institutions, treatment institutions, prevention agencies) whose resources increase in the face of such perceived threats. The propensity to stir alarm is virtually unconscious for those who are seeking, or who have been given, institutional ownership of the drug problem arena. A significant advancement of the late 20th century was the establishment of baseline data (annual household and school surveys) that provide a scientific foundation to verify or refute such stakeholder claims.

Epidemics and Disinformation

During the alarm phase of a perceived drug epidemic, initial reports of drug effects are notoriously unreliable and generate their own harmful effects. The evolving portrayal of the effects of pre-natal cocaine exposure is illustrative. Anecdotal reports of the mid-1980s triggered a media frenzy about "crack babies" that in turn led to the removal of a large number of infants from mostly poor women of color. The children were branded as a Abiological underclass,@ and dire warnings were issued about the massive resources schools would require to meet their special educational needs. Later reports, based on rigorous scientific research, provided a very different conclusion: pre-natal cocaine exposure produces subtle effects in some infants that can be either reversed by the brain itself or through environmental support. In retrospect, these infants may have been harmed more by the label "crack baby" than prenatal drug exposure.

Drugs and War

Wartime conditions often spawn increased psychoactive drug consumption by bringing large numbers of young people into intimate social contact, suspending family- and community-of-origin norms governing drug-taking behavior, introducing new drugs for which there are no pre-existing prohibitions or ground rules for use, and by providing a medium for the self-medication of fear and boredom. This principle is an enduring theme in American history, from concern over excessive drinking in the Continental Army to concern about heroin addiction among soldiers in Vietnam. The closer the wartime environment is to the civilian environment of origin, the great the likelihood of later transfer of drug use from military to civilian life.

Principles of Addition and Subtraction

Personal vulnerability to the powers of psychoactive drugs increase under two circumstances: 1) when it is discovered that the drug can add something (pleasure, energy, confidence, tranquility, people) to one's life that is missing, and 2) when it is discovered that the drug can hide or remove something (pain, boredom, shyness) that is undesirable. The interaction between humans and drugs is at its most basic level a process of addition and subtraction.

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Waiting for Breaking Good: The Media and Addiction Recovery

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The major media outlets have long been chastised for the content and style of their coverage of alcohol- and drug-related problems. Such criticisms include the glamorization of drug use, the demonization of drug users, and charges that the media is complicit in ineffective drug policies. Few have raised parallel concerns that popular media coverage of addiction recovery is rare, often poorly selected, and told through a lens that does little to welcome the estranged person back into the heart of community life. If media representatives do not "get it" ("it" being recovery), then what precisely is it that they don't get? What are the mistold and untold stories and their personal and public consequences to which media leaders ought to be held accountable?

Having closely observed such coverage for nearly half a century, I would offer twelve points from the perspective of a long-tenured recovery advocate.

1. Distorted media coverage of active addiction fuels social stigma and contributes to the discrimination that many people in recovery face as they enter the recovery process. Caricatured and sensationalized media images of addiction—from hijacked (diseased, deranged, dangerous) brains to the most lurid stories of crime, violence, neglectful/abusive parenting, insanity, and infectious disease—minimize problem recognition among those with AOD problems and, by cultivating fear and revulsion among the general population, remove the welcome mat to community reentry for those seeking recovery. When combined with the failure to provide alternative associations, images, and expectations of recovery—images that would distinguish the status of addiction and the status of addiction recovery, these media-shaped social attitudes push those who would potentially seek recovery further and further into subterranean subcultures. As an example, consider the images of methamphetamine addiction in the

popular media. Now imagine a person seeking recovery from methamphetamine dependence confronting such stereotypes as they seek to reconstruct their social world and lifestyle. Now imagine how images affect the community's willingness to welcome home these lost sons and daughters and mothers and fathers. Also imagine how the emaciated images of the meth stick figures inhibit the help-seeking of the majority of people experiencing methamphetamine dependence who look nothing like those images.

2. Media coverage of addiction recovery is rare and tangential. If the media's coverage of alcohol and drug-related topics was plotted on a map, one would be hard-pressed to find the location of recovery. A survey conducted some years ago on behalf of Faces and Voices of Recovery revealed that the American public understood addiction *recovery* to mean that a person was trying to resolve an alcohol or drug problem rather than as a stable and sustained state of having resolved such problems. Such a view is understandable in light of just how infrequently the story of people in **long-term** recovery is conveyed through the major media channels, whether in the form of news, film, television dramas, or print and electronic media. The rarity of recovery portrayals through those media outlets is even more pronounced for people of color where its effects are even greater due to the saturation of images linking people of color and addiction. People of color and communities of color are wounded by the magnified coverage of their addiction stories and the marked absence of their recovery stories. When the media cover the addiction/recovery story of people judged to be "one of us" or of one of their own (e.g., ABC's Elizabeth Vargas), a compassion evoking story is told about the source of excessive AOD use—physical pain, emotional trauma or distress, death of a loved one, etc.). No such compassion-evoking explanations are offered for those judged to be "one of them"—poor people of color, people living with HIV/AIDS, people in the criminal justice or child welfare systems. Medical models of understanding addiction/recovery are applied to the privileged; moral and criminal models are applied to the culturally disempowered.

3. The media mistakenly conflates recovery with active addiction and addiction treatment with recovery. Peripheral recovery references can be found in the sensational coverage of celebrities of the moment announcing their latest sagas of "crash, burn, and back to rehab" or in the press conferences of politicians, sports figures, actors, musicians, and notable others expressing (in words written by their publicists) a profound apology for their recently-exposed public indiscretions and their just-discovered but profound commitment to recovery. These are not the voices of recovery; these are the voices of addiction seeking a reprieve to chase the dragon another day. Ironically, when real recovery is actually achieved under such circumstances, media attention disappears. An unending supply of experts are available to comment on a celebrity's out-of-control addictive behavior, but none are shown explaining how that out-of-control behavior later disappeared. (For example, compare the wild media frenzies and the excruciating details of Robert Downey Jr.'s addiction-related misadventures with the sparse attention to and rare acknowledgement of his sustained recovery story.)

When celebrities enter addiction treatment, it is often referred to as an entry into recovery (or a "trip to recovery".) Entering treatment is not synonymous with entry into recovery. Entering treatment is as likely to a benchmark in one's addiction career as the beginning of sustainable recovery—a

respite from rather than an end of addiction. The media's conflation of treatment and recovery leave people in long-term recovery lamenting, "They just don't get it!"

4. Media outlets portray addiction recovery as an exception to the rule. Recovery is too often portrayed as the heroic efforts of a small, morally enlightened minority, yet scientific studies of alcohol and drug problems in the community consistently reveal that most addictions end in recovery, not with perpetual addiction, prolonged institutionalization, or death. Recovery should be an expectation of every individual and family experiencing an alcohol or other drug problem. The American media fails to convey that hope and expectation. Recovery is the norm, and the normality of recovery is the most important missing story.

5. Media coverage of drug-related celebrity mayhem and deaths contributes to professional and public pessimism about the prospects of successful, long-term addiction recovery. Categorizing repeated mayhem as "relapses" further conveys a failure of recovery when most often there has been no sustained period of recovery preceding such events. These events are manifestations of sustained addiction, not a loss of recovery. I am not suggesting a moratorium on reporting such events, only placing these details within a larger context—noting the value of professional treatment and peer recovery support for millions of individuals and helping readers/viewers understand what special circumstances may have made these valued aids less effective for this particular individual and what we as a community might do to change such circumstances. Media coverage portraying addiction treatment as a refuge through which spoiled stars escape the consequences of addiction rather than as portals of entry into recovery contribute to addiction treatment facilities being used for precisely such purposes and being perceived as such by the public and policymakers. The addiction treatment industry and recovery communities share the responsibility of not providing visible alternatives to these images.

6. When the story of recovery is told, it is most often told from the perspective of the initiate rather than the perspective of long-term recovery. This is analogous to interviewing an infant about the meaning of life. The person who is most frequently invited to step to the microphone to talk about recovery is often the least qualified by knowledge and experience to do so. Here is the question for any defensive media representatives reading this: After examining all the stories related to addiction recovery you have produced, written, or performed in the past five years, what percentage involved telling the stories of individuals and families with more than ten years of continuous recovery? That is the missing story! People in the early months and even years of recovery can detail the *recovery from* story but the *recovery to* story takes years to create and understand. Many people in long-term recovery would shudder at the thought of having shared their "wisdom" about recovery at such a fledgling stage of recovery. Media coverage of intervention and treatment processes is often exploitive and poses potential harm to those participating. Who could have conceived that placing people in active addiction--some of the most narcissistic people on earth--in front of television cameras would ever produce an authentic, let alone helpful, experience?

7. When personal recovery is conveyed by the media as a dramatic story of redemption, the media often inflate and elevate the recovering person to a pedestal position and then circle like piranhas in a feeding frenzy at the first sign of any failure to live up to that imposed image. Who could forget the cultural phenomenon of James Frey's *A Million Little Pieces* and the plummet from grace aftermath?! People in recovery who readily volunteer or are enticed into this pedestal role should rightly fear the precarious footing of this position and the intentions of those who will profit equally from their rise and their fall with little regard for the final outcome as long as it draws attention and sells products. Getting seduced into such transient ego-inflation creates a sense of recovery-endowed privilege and entitlement and a growing gap between this pedestal image and one's real internal experience. Interviews with people in recovery should come with a warning label.

8. The media seeks to make the personal recovery story as dramatic as possible by emphasizing the details of the addictions story while glossing over the processes and fruits of long-term personal and family recovery. When recovery is portrayed, the focus is on the most lurid and dramatic elements of past addiction and early recovery initiation, not the processes of long-term recovery. (Eliciting these dramatic details involves asking the most invasive of questions—questions never asked of those with other medical conditions—as if one's past addiction status eliminates any right to privacy.) In media coverage of recovery, the language of recovery (e.g., hope, healing, gratitude, humility, humor, restitution, service, simplicity, spirituality), if present at all, is smothered by the more embellished language used to tell the pre-recovery story (e.g., the language of crisis, hopelessness, struggle, pain, suffering, failure, and harm to others). The lasting memory of exposure to such stories is not usually one of stable recovery and community contribution. While the sensational and dramatic are media staples, the essence of recovery is the displacement of such drama by living out these values of humility, simplicity, and unheralded service. When a life in recovery is not "newsworthy" by recent journalistic standards, this is a good thing.

9. The media fixation on celebrity addiction and recovery is a diversion from a much larger and more important story. THE missing story is not that a celebrity whose life few can relate to achieves **long-term** recovery from addiction, but that millions of individuals and families have achieved such recoveries. Similarly, THE story of recovery advocacy is not the story of how one recovery advocate turned his or her pain into service, but that 125,000 culturally and politically mobilized Americans in recovery broke centuries of silence by participating in public recovery celebration and advocacy events in 2013. The words and images of that larger story have yet to be revealed in any depth by mainstream media outlets.

10. The media tell the story of recovery only as a personal story rather than a larger story of the role of family and community in addiction recovery. The media is quick to tell the stories of families who have lost sons or daughters to addiction. Why don't we see the same attention devoted to families whose sons and daughters have recovered from addiction and how their families also experienced a recovery process? The media is quick to depict communities "plagued" by addiction, but rarely tells the stories of communities consciously creating the space in which resilience and recovery are flourishing.

11. The rare media portrayals of recovery often depict only a single pathway of addiction recovery—specialized addiction treatment followed by lifelong affiliation with a 12-Step recovery program. While many people successfully follow that pathway, this singular portrayal fails to convey the growing varieties of recovery experience; the secular, spiritual, and religious alternatives to 12-Step programs; and the experience of persons who achieve recovery without benefit of professional treatment and participation in a recovery mutual aid society. And stories of medication-assisted recovery are notably masked behind sensationalist and pejorative coverage of these medications and the patients who rely on them for recovery initiation and maintenance.

12. The media is only just beginning to recognize newly emerging recovery support institutions and the existence of an ecumenical culture of recovery that are uniting people from diverse pathways and styles of long-term recovery. For more than 150 years, specialized support for addiction recovery has rested in two social institutions: recovery mutual aid fellowships (e.g., AA, NA, Women for Sobriety, Smart Recovery, and Celebrate Recovery) and professionally-directed addiction treatment. Today, new institutions (recovery community organizations, recovery community centers, recovery residences, recovery schools, recovery industries, recovery ministries, recovery cafes, to name just a few) are dotting the American landscape. This shift toward creating the physical, psychological, and social space in local communities within which recovery can thrive is of enormous historical significance, but still receiving only scant notice from mainstream media.

As the eternal optimist, I await with great anticipation a new quality of media coverage of addiction recovery. The Breaking Bad stories have been told ad nauseam. It's time for a new generation of journalists, scriptwriters, and filmmakers to convey the Breaking Good stories.

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Troubling New Directions in U.S. Drug Policy

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Recovery advocates around the country are deeply concerned about what appear to be troubling regressions in U.S. drug policies under the new presidential administration. My concerns, briefly summarized below, expand on a blog I posted earlier this month that generated considerable interest among my readers.

1. When alarm was raised on the 2016 presidential campaign trail regarding rising rates of opioid addiction and related deaths, then candidate Donald Trump promised he would stop the flow of drugs coming into the U.S. by building a wall on the U.S.-Mexico border, yet remained virtually silent on the major roles American pharmaceutical companies and medical practitioners have played, and continue to play, in the current opioid epidemic. No wall will solve America's drug problems. No wall will check the insatiability of American appetites for psychoactive drugs, nor will any wall counter the greed-fueled ingenuity of the licit and illicit industries that exploit those appetites.

2. President Trump praised Philippine President Rodrigo Duterte and later invited him for an official state visit to the White House—the same Duterte who has likened himself to Hitler, expressed his desire and intent to "slaughter" his country's three million drug addicts, and whose violence-inciting rhetoric and policies are responsible for the extrajudicial killing of more than 9,000 suspected addicts and bystanders in anti-drug raids by police and government-sanctioned vigilante groups. Duterte's actions have been universally condemned by human rights groups and leaders throughout the world. Any actions by an American president to lend legitimacy to Duterte's presidency would be morally reprehensible and a dark foreshadowing of future directions in American drug policy.

3. President Trump appointed a new presidential commission on opioid addiction, while virtually ignoring the landmark Facing Addiction in America: The Surgeon General's Report on Alcohol, Drugs, and Health prepared by the nation's leading addiction experts and released in late 2016 by Surgeon General Dr. Vivek Murthy. *Facing Addiction in America* is one of the most important policy documents in the history of drug control policy. To ignore the best scientific research and the proposed strategies of America's leading addiction and public health experts would be a travesty and a critical lost opportunity. The dismissal of Dr. Murthy by the Trump administration adds further insult

to injury and marks a deepening loss of national drug policy expertise.

4. The House of Representatives passage of the American Health Care Act of 2017 eliminates treatment for substance use disorders as a health care benefit. If approved by the Senate and signed by the President in its current form, this legislation would substantially reduce access to substance use treatment in the U.S., including access within key states hardest hit by the opioid epidemic—and ironic if it was not so tragic, states that delivered the White House to Donald Trump.

5. The institution responsible for America's drug control strategy, the White House Office of National Drug Control Policy, lacks a permanently-appointed director, continues to lack even a functioning website, and faces a proposed 95% cut in the President's draft budget. The elimination or decimation of ONDCP would significantly diminish federal leadership in helping states and local communities address addiction and related problems. (See Dr. Keith Humphreys' related commentary.)

6. Newly-appointed Attorney General Jeff Sessions just issued a new directive to federal prosecutors calling for maximum sentences and mandatory minimum sentences for non-violent drug offenders and the expanded use of private prisons. This marks a return to failed drug policies of the 1980s that spurred the largest experiment in mass incarceration in U.S. history and its broad spectrum of untoward social and economic consequences—including its destructive effects on low-income communities of color. This reverses what has been growing bipartisan consensus on the ineffectiveness of these earlier policies in terms of their excessive costs, low rehabilitative outcomes, and their harmful social effects. My larger concern is that prison expansion creates conditions through which addicted Americans become the raw materials required to fuel institutional growth, corporate profit, and secure employment within otherwise economically oppressed (and often White) communities. An ever-growing prison industrial complex will serve as a powerful lobbying force for the increased stigmatization, de-medicalization, and criminalization of addiction.

7. Newly appointed Secretary of Health and Human Services Dr. Tom Price recently commented that treating opioid addiction with medications amounted to "just substituting one opioid for another"—a statement contradicted by decades of scientific reports from medical and public health panels and the cumulative clinical experience of addiction treatment practitioners specializing in the treatment of opioid addiction. Any efforts by this administration to de-value medication-assisted treatment of addiction or delegitimize the legitimacy of medication-assisted recovery opioid addiction would be an unthinkable regression.

8. Dr. Elinore McCance-Katz, nominee to head the Substance Abuse and Mental Health Services Administration, has proposed a focus on enhanced access to inpatient psychiatric treatment and access to psychiatric medications and a decreased emphasis on community education and recovery support services. Her appointment and declared focus could signal potential abandonment, or a marked reduction in, efforts to develop long-term, community-based recovery support systems for persons experiencing mental health and/or substance use disorders.

Collectively, these eight concerns reflect not the arrival of bold new leadership and innovative ideas but an erosion of expertise and policy regressions that will exert potentially prolonged harm to individuals, families, and communities. Every effort must be made to resist and counter these policy directions.

About the Author: William White, author of *Slaying the Dragon: The History of Addiction Treatment and Recovery in America*, has worked in the addictions treatment field since the late 1960s. He thanks several reviewers who offered comments on an early draft of this short essay.