

# Family **TO** Family

TOOLS FOR  
Rebuilding Foster Care

## Back From the Brink

### Women, Crack, and the Child Welfare System

THE CHALLENGE OF DRUG ABUSE IN CHILD WELFARE, PART ONE

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## **A C K N O W L E D G M E N T S**

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Jill Kinney, Ph.D.

Kathy Strand, M.S.W.

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## I N T R O D U C T I O N

### **The Annie E. Casey Foundation's Mission in Child Welfare**

The Annie E. Casey Foundation was established in 1948 by Jim Casey, a founder of United Parcel Service, and his sister and brothers, who named the Foundation in honor of their mother. The primary mission of the Foundation is to foster public policies, human service reforms, and community supports that better meet the needs of vulnerable families.

The Foundation's work in child welfare is grounded in two fundamental convictions. First, there is no substitute for strong families to ensure that children grow up to be capable adults. Second, the ability of families to raise children is often inextricably linked to conditions in their communities.

The Foundation's goal in child welfare is to help neighborhoods build effective responses to families and children at risk of abuse or neglect. The Foundation believes that these community-centered responses can better protect children, support families, and strengthen communities.

Helping distressed neighborhoods become environments that foster strong, capable families is a complex challenge that will require transformation in many areas. Family foster care, the mainstay of all public child welfare systems, is in critical need of such transformation.

### **The Family to Family Initiative**

With changes in policy, in the use of resources, and in program implementation, family foster care can respond to children's need for out-of-home placement and be a less expensive and often more appropriate choice than institutions or other group settings.

This reform by itself can yield important benefits for families and children, although it is only one part of a larger effort to address the overall well-being of children and families in need of child protective services.

*Family to Family* was designed in 1992 in consultation with national experts in child welfare. In keeping with the Annie E. Casey Foundation's guiding principles, the framework for the initiative is grounded in the belief that family foster care must take a more family-centered approach that is: (1) tailored to the individual needs of children and their families, (2) rooted in the child's community or neighborhood, (3) sensitive to cultural differences, and (4) able to serve many of the children now placed in group homes and institutions.

The *Family to Family* Initiative has encouraged states to reconceptualize, redesign, and reconstruct their foster care system to achieve the following new system-wide goals:

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*The Foundations's goal in child welfare is to help neighborhoods build effective responses to families and children at risk of abuse or neglect.*

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- To develop a network of family foster care that is more neighborhood-based, culturally sensitive, and located primarily in the communities where the children live;
- To assure that scarce family foster home resources are provided to all those children (and only to those children) who in fact must be removed from their homes;
- To reduce reliance on institutional or congregate care (in hospitals, psychiatric centers, correctional facilities, residential treatment programs, and group homes) by meeting the needs of many more of the children in those settings through family foster care;
- To increase the number and quality of foster families to meet projected needs;
- To reunite children with their families as soon as that can safely be accomplished, based on the family's and children's needs, not the system's time frames;
- To reduce the lengths of children's stay in out-of-home care; and
- To decrease the overall number of children coming into out-of-home care.

With these goals in mind, the Foundation selected and funded three states (Alabama, New Mexico, and Ohio) and five Georgia counties in August 1993, and two additional states (Maryland and Pennsylvania) in February 1994. Los Angeles County was awarded a planning grant in August 1996. States and counties funded through this initiative were asked to develop family-centered, neighborhood-based family foster care systems within one or more local areas.

Communities targeted for the initiative were to be those with a history of placing large numbers of children out of their homes. The sites would then become the first phase of implementation of the newly conceptualized family foster care system throughout the state.

## The Tools of *Family to Family*

All of us involved in *Family to Family* quickly became aware that new paradigms, policies, and organizational structures were not enough to both make and sustain substantive change in the way society protects children and supports families. New ways of actually doing the work needed to be put in place in the real world. During 1996, therefore, the Foundation and *Family to Family* grantees together developed a set of tools that we believe will help others build a neighborhood-based family foster care system. In our minds, such tools are indispensable elements of real change in child welfare.

The tools of *Family to Family* include the following:

- Ways to recruit, train, and support foster families;
- A decisionmaking model for placement in child protection;
- A model to recruit and support relative caregivers;
- New information system approaches and analytic methods;
- A self-evaluation model;
- Ways to build partnerships between public child welfare agencies and the communities they serve;
- New approaches to substance abuse treatment in a public child welfare setting;
- A model to confront burnout and build resilience among child protection staff;
- Communications planning in a public child protection environment;
- A model for partnerships between public and private agencies;
- Ways to link the world of child welfare agencies and correctional systems to support family resilience; and
- Proven models that move children home or to other permanent families.

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We hope that child welfare leaders and practitioners find one or more of these tools of use. We offer them with great respect to those who often receive few rewards for doing this most difficult work.

## O V E R V I E W

Crack cocaine has been a focus of the media since the mid- to late 1980s. Crack use has been portrayed as a plague, a disaster, a destructive force in poor neighborhoods, and the cause of a spiral of violence (Belenko, 1993). Mothers who use crack have been demonized as selfish and uncaring and even as sex-crazed monsters. Cocaine has been said to kill the parental instinct (Kearney, et al., 1994), possibly causing a mother not only to neglect but to kill her children (Belenko, 1993).

The purpose of Section I of this paper is to summarize and analyze some of the empirical and anecdotal information that has emerged as social scientists and practitioners struggle to understand and overcome the challenges the drug presents. We hope to gain some insight into the accuracy of the media reports: Is the crack situation as bad as we hear? Is there anything that can be done? Specifically, we wish to evaluate the information in its relevance for the child welfare system and for ways we might best protect and nurture children whose lives are touched by crack. We hope this section will help us develop a realistic data-based perspective.

Within that context, we hope Section II will help to evaluate our current effectiveness in assessing, engaging, facilitating, and maintaining change in crack-addicted women. We also hope it will help us to set goals and develop concrete plans for moving beyond our current status. The problems of women and crack are difficult and complicated, and we have many possible ways to improve our response to them. We can do better. In Section III we will present some specific approaches at the systemic, model design, and frontline-practice levels.

# W O M E N , C R A C K , A N D T H E C H I L D W E L F A R E S Y S T E M

Crack is a potent, damaging drug. It affects hundreds of thousands of women and children. Although researchers and practitioners contend about the degree of damage done, they agree that we do not yet know how to help women on crack, or their families, as effectively as we would like.

## **What Is Crack Cocaine?**

Crack is a form of smokeable cocaine that is simple and cheap to manufacture. It is usually prepared by mixing powdered cocaine hydrochloride with baking soda to form a paste, and heating that until it dries. The dried rock is then broken into chunks and placed in small plastic vials. These vials are sold for \$5.00 and up, depending on the size and number of rocks inside. The chunks are heated and the vapors inhaled, either in a marijuana or tobacco cigarette or a small glass pipe (Belenko, 1993).

## **The Effects of Crack on the Women Who Use It**

Crack triggers immediate psychological and physiological reactions in the user. Other behavioral and environmental events are also associated with the drug.

### **Physical Reactions**

Crack use involves intense neurochemically based cravings. The physiological action of crack in the brain is the same as that of cocaine, although in contrast to snorted cocaine, which must go first through the circulatory system before it gets to the lungs, crack smoke is rapidly absorbed through the lungs and enters the brain in larger doses. Cocaine increases the supply of the neurotransmitter dopamine in areas of the brain that control pleasure sensations and euphoria. It produces a brief but intense euphoric high that begins within seconds of inhaling and lasts from 2 to 15 minutes. This occurs because cocaine blocks the reabsorption of circulating dopamine back into the nerve endings. The continued presence of dopamine stimulates the neurons and causes the euphoria.

Once the dopamine is depleted, the user experiences a crash or depression. In chronic smokers, dopamine production is decreased overall. This increases depression, which increases the desire to get that original feeling of euphoria. The chronic smoker, though, finds it more and more difficult to reach that level of euphoria, finally smoking to avoid feeling bad rather than to feel good.

Physical reactions to crack can include seizures, chest pain, constantly running nose, nasal burns and sores, sore throat, and hoarseness. Users may experience shortness of breath, cold sweats, tremors, malnutrition, severe weight loss, insomnia, and neglect of personal hygiene. Some may have singed eyelashes and eyebrows from smoking pipes whose vapors burn off facial hair.

Most who write about crack consider cocaine to be our most addictive drug, and crack to be the most addictive form of cocaine (Rosecan & Spitz, 1987). They often describe users behavior as extreme and almost out of control. Many researchers (Washton, 1987) note the rapid addiction potential of crack, claiming that many

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users become addicted within six months of initial use. Rosecan et al. (1987) estimate that escalation to compulsive crack smoking can occur within days to weeks compared to many months or years for powdered cocaine.

Other researchers, however, believe that even compulsive crack smokers are a diverse group, and that some live normally except to borrow money for drugs, or take advances against their paychecks. Some may limit or confine drug use to payday weekends (Wallace, 1990a), at least for a time.

Other reports (Belenko, 1993) indicate that not all mothers who use crack are addicted and that periods of abstinence can be achieved without treatment. Users show widely varying patterns of crack use. Some users may be able to control their intake. Frank et al. (1988) found that one third of pregnant women using cocaine used it less than once a month, and that 25 percent used it three or more times per week.

A summary of varying viewpoints on the ability of women to control their crack use is shown in Table 1.

**T A B L E 1**  
**Varying viewpoints on the ability of mothers to control crack use**

<b>Researcher</b>	<b>Conclusions</b>
Koppelman & Jones (1989) and Inciardi (1992)	The typical crack user goes on binges lasting 2-3 days until the drugs and money run out and he/she collapses physically, often ignoring his or her need to eat, sleep, or bathe.
Washton & Gold (1987)	Smoking crack almost invariably leads to more compulsive, higher-dose use.
Wallace (1990a)	Even compulsive crack smokers are a diverse group. Some may only borrow money for drugs or take advances against their paycheck. Some successfully limit or confine the drug use to payday weekends, at least for a time.
Belenko (1993)	Not all mothers who use crack are addicted and periods of abstinence without treatment are achievable, with users showing widely varying patterns of crack use. Some users may be able to control their intake.
Frank et al. (1988)	Crack use varied among the pregnant women studied. One-third used it less than once a month and 25 percent used it three or more times per week.

**Psychological Reactions**

Women who use crack may experience profound personality changes, confusion, anxiety, and depression. They may be irritable, short tempered, restless, or lethargic. They may be

suspicious of friends, loved ones, and co-workers. Thinking may be impaired, and they may have difficulty in concentrating and remembering. They may also suffer from weakness and fatigue. They may be aggressive



and experience delusions, paranoia, and visual, auditory, and tactile hallucinations (Rusche, 1993).

### **Behavioral Ramifications**

Many behaviors are attributed to crack. Some researchers describe users as lying, stealing, and doing virtually anything to satisfy intense cravings arising as a consequence of the neurochemical disruptions in brain functioning (Rosecan & Spitz, 1987). Others describe users as typically smoking for as long as they have crack, or the ability to purchase more with money, personal belongings, sexual services, stolen goods, or other drugs. They say it is rare for smokers to have a single hit. More commonly, they will spend \$50 to \$500 during a three- or four-day binge. The financial burden can be staggering (Inciardi, Lockwood, Pottieger, 1991).

Some believe that the physical consequences of hard-core crack use are so severe that users need hospitalization for three to five days (Rawson, 1990). It is possible that unless they have respite from cocaine, are able to sleep and receive nutritious food, such people are not coherent enough to even hear the therapist.

**Sexuality:** Women addicted to crack have frequently been depicted as sex-crazed or hyper-sexual. Extreme need for the drug often forces women to perform degrading sexual acts in exchange for the drug or money (Fullilove & Fullilove, 1989). Though it is true that many women addicted to crack but without financial resources engage in a lot of sexual activity, they may not be enjoying or even desiring sex, but desiring crack (Henderson et al., 1995). Most likely, crack cocaine is not a sexual stimulant for women. Women's access to illegal income is more limited than it is for men. Prostitution is the easiest and most lucrative, reliable way for women to finance drug use (Inciardi et al., 1991).

**Parenting ability:** Most researchers and practitioners believe women on crack face overwhelming odds against being adequate parents. This belief is reflected in increased foster care placement rates since the mid-1980s when the drug first became widely available. Besharov (1990) sees this increase as primarily due to neglect and abandonment of children by crack-addicted mothers. This indicates decisions by both child welfare systems and mothers that children cannot be cared for adequately in homes where crack use is occurring.

The North American Council on Adoptable Children (1996) reports that foster care caseloads have more than doubled in the last 10 years in five of the largest states. Infants and younger children are entering care in greater numbers and are staying longer. Alcohol and drug abuse are factors in the placement of more than 75 percent of the children who enter care (GAO, 1994). From 1986 to 1991, the proportion of young children entering care who were estimated to have been exposed prenatally to cocaine increased from 17 to 55 percent (GAO, 1994).

Wallace (1991a) concurs that women on crack have a difficult time parenting. In a study of crack smokers in New York City, she found that the public agency, the Bureau of Child Welfare (BCW), had placed children with relatives in 30 percent of the families and placed 4.3 percent in foster care. Another 15.7 percent of children were being cared for by relatives without formal BCW involvement, for a total of 52.9 percent of crack-using mothers who were no longer parenting their children. The majority (54.3 percent) of crack smokers report some kind of family discord related directly to their use of crack.

Walker (1991) focuses on African American children removed from drug-abusing households. According to his data, these children are returned home from foster care at only half the rate of children from non-drug-abusing households. The adoption rate

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for these children is only 9 percent. After 26 months, almost 75 percent of the children of substance abusers were still in foster care, compared to less than half the children whose parents did not abuse drugs.

Though it is clear that foster care placement rates have risen, largely due to drug-abusing parents, we need also to look at studies of the actual parenting behaviors of women who are addicted to drugs, especially crack. We do not know conclusively how much caseworkers bias toward placement is due to the users actual behavior as opposed to stigma and revulsion against crack users in general.

Howard (1994) reports that mothers who used drugs heavily were significantly less sensitive, responsive, and accessible to their infants. Physical contact was poor in both quantity and quality, and there was less acceptance of the infant. The children also showed insecure attachments to their mothers.

Some of the most interesting information about the potential of women on crack to parent comes from the women themselves (Hawley et al., 1995 and Kearney, Murphy & Rosenbaum, 1994). Two studies used a series of in-depth interviews of mothers addicted to crack. In Hawley's study, participants all expressed love and deep concern for their children's welfare, but it was clear that most of them had great difficulty taking care of their children while using drugs.

Some form of emotional neglect or abuse was mentioned by 60 percent of the mothers. They described themselves as detached and uninvolved with their children and as interacting with them only when necessary. They said they rarely responded to their children's bids for attention and showed little affect in their interactions with them; 64 percent mentioned some type of physical child neglect when they were using drugs.

Kearney and her co-authors describe the central process of mothering on crack as defensive compensation: defending children

from drugs and the drug life, shielding one's identity as a mother, and trying to make up for crack's negative effects on mothering. All mothers made these efforts, but their persistence and success varied over time according to their personal and social resources, as will be described later. The process involved several active strategies, each of which took several forms.

Mothers tried hard to separate children and drugs, to keep children physically apart from cocaine use and to keep their own drug-user identity distant from their role as mother. For example, drug use in front of children was taboo. One mother said, I may be a crack monster; but at least I have morals about myself. Women did not underestimate children's ability to recognize illicit behavior. Another woman said she had told a crack-smoking mother: You have to put your kids in another room. I'm not going to show your kids how to do this. Mothers tried to budget, separating family money from drug money: I was like spending I'd say probably about \$150 a month of my own money, not my kids' money. Now, that's something I never did do.

When paychecks or welfare checks arrived, several mothers described their deliberate efforts to meet household needs before going out to buy crack. Mothers also budgeted their time and personal energy. For example, a number of mothers told of needing to get up early to care for children and therefore limiting their evening crack smoking in order to get enough rest.

For almost 70 percent of the mothers interviewed for this study, strategies for upholding mothering standards eventually broke down. When mothers perceived that their mothering was inadequate, they either reduced their drug use or intensified their efforts at defensive compensation, but many were unable to pull themselves out of the drug scene or exhausted their emotional or financial resources. At this point, some mothers decided that to entrust their

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children to another caregiver for a period of time would be in the children's best interest.

Zuckerman (1994) points out that the depression and violence which can accompany crack use are, in themselves, risk factors. Depression alone, without drug use, adversely affects parenting. Drug use, including crack use, increases the likelihood that a woman will be a victim of violence, which puts children at a higher risk of violence.

Besharov (1996) believes we should assume that parental addiction to crack and other drugs will not be cured in the foreseeable future, even if the parent is participating in the best drug treatment programs.

...even the best drug treatment programs should not be expected to do more than break patterns of crack use temporarily because of the addictive qualities of the drug and the social factors that encourage addiction. That is why drug treatment professionals consider crack addiction to be a chronic, relapsing syndrome. So should child welfare professionals. (p. 34)

In fact, we do not know exact behavior patterns for all who use crack. It may be that some women do use it sparingly without negative effects on their children. People have many legal, psychological, and social reasons for concealing their use whenever possible. If any do use the drug once or twice, or more frequently without total loss of control, it is unlikely that they will come to the attention of human services. To date, we know that many women who use crack do seem to lose control of their behavior. We just do not know how many retain some control, and what their pattern of use might be.

### **The Effects of Mothers' Use of Crack Upon Infants and Children**

Babies exposed to crack *in utero* have been described as crack babies, a biological underclass and a lost generation. Besharov (1989) estimated that 30,000 to 50,000

babies a year are born exposed to crack. The exact effects of this exposure are not known. Studies are conflicting. Many variables are involved that handicap our ability to interpret results.

### **Studies Showing Impairment**

A number of studies of cocaine-exposed infants found premature separation of the placenta and intrauterine vascular accidents in the fetus (Bingol, Fuchs, Diaz, Stone, & Gromisch, 1987; Cregler & Mark, 1986; Chasnoff, Bussey, Savich & Stack, 1986). Others note congenital anomalies that may be responsible for spontaneous abortion or stillbirth (Hoyme et al., 1990). Infants exposed to crack *in utero* may have lower birth weight (Chasnoff, Griffith, MacGregor, Dirkes & Burns, 1989; Petitti & Coleman, 1990) and smaller head circumference (Oro & Dixon, 1987).

Other studies show other kinds of impairment, such as in infants' orientation and organizational ability (Chasnoff et al., 1985, 1989). Prenatal drug withdrawal may lead to a lack of interactive behavior with caretakers and the environment. Irritability and avoidance behavior can delay early interactive learning and interfere with bonding (Burg & Schwartz, 1988). There is increased risk for sudden infant death syndrome, and increased risk for motor dysfunction (NIDA, 1994).

### **Uncertainty About Causal Relationships**

Zuckerman (1994) is eloquent about the interaction between maternal limitations and the effects of drugs on infants:

Consider, for example, a child born to a cocaine-using mother who did not eat well during her pregnancy and received minimal prenatal care. Following a three-day hospitalization, the infant has difficulty remaining alert and is minimally responsive. The child's passivity engenders maternal feelings of inadequacy that may deepen already existing depressive symptoms and promote

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*These differing methods of conceptualizing problems lead to different hypotheses of change and different methods of intervention.*

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*Delattre points out that children learn much by example, and that the neighborhoods where they live encourage them to rely on impulse and violence to get their needs met.*

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continued reliance on cocaine to alleviate these painful feelings. During the first year, the mother's attempts to get her infant's attention lead to overstimulation, general irritability, and, at times, inconsolable crying. The mother's feeling of inadequacy and depression increases, and she continues to use drugs and alcohol to self-medicate these painful feelings. In the second year of life, as the child strives for independence, struggles develop between the mother and her toddler. The mother sets unusual or inconsistent limits, and most interactions with her child are negative and involve commands, especially on the days following a drug or alcohol binge. At two years of age, the child is hyperactive and impulsive, with delayed language development.

Many who analyze available data express uncertainty about the causal relationship between drug use and adverse birth outcomes (Lutiger et al., 1991; Mathias, 1992; Woodhouse, 1994). Determining the precise effects of cocaine exposure upon infants is extremely difficult, because their mothers have typically used and abused many different drugs during pregnancy. Most research does not include appropriate controls for the effects of potential confounding factors such as inadequate nutrition, low socioeconomic status, and poor general health. Also, most sample sizes are small and study dropout rates are high. Effects of cocaine upon infants and children are also confounded by the effects of postnatal care.

Because of our negative stereotypes about crack users, we may seek information that confirms our hypotheses about them. A study of papers submitted to the Society of Pediatric Research found that studies showing that ingestion of cocaine had adverse effects on the fetus were five times more likely to be published than those that found no effects (Koren et al., 1989; Pollitt, 1990).

Some believe that the nature (Coles, 1992) and permanence (Mathias, 1992) of the damage caused by prenatal exposure to cocaine have been exaggerated (Drucker, 1990; Woodhouse, 1994) and that the vast majority of infants born to drug-using mothers are as healthy as other infants born in poverty (Drucker, 1990). They state that 66 percent of crack-exposed infants suffer no adverse consequences at birth, and it appears that both prenatal and postnatal interventions can prevent development problems (Chasnoff, 1990; Humphries, 1993; Mathias, 1992). Other studies support the contention that the majority of cocaine-exposed infants are born without significant or pervasive physical or neurobehavioral impairments and show normal development in later infancy (Mayes, Granger, Bornstein & Zuckerman, 1992).

Large-scale studies of the subsequent development of cocaine-exposed children have only recently begun. Thus, how these children will fare over time and the effects of their development on parents, teachers, and schools remain uncertain. Table 2 presents a summary of current thinking.

**T A B L E 2**  
**Varying viewpoints on the effects of mothers' use of crack upon infants and children**

<b>Researcher</b>	<b>Conclusions</b>
Drucker (1990)	The vast majority of infants born to drug-using mothers are as healthy as other infants born in poverty.
Mayes, Granger, Bornstein & Zuckerman (1992)	The majority of cocaine-exposed infants are born without significant or pervasive physical or neuro-behavioral impairments and show normal development in later infancy.
Mathias (1992)	Both prenatal and postnatal interventions can prevent developmental problems.
Hawley, Halle, Drasin & Thomas (1995)	The majority of cocaine-exposed infants are born without significant or pervasive physical or neurological impairments and show normal development in later infancy. Though a study of prenatally exposed children of addicted mothers found they did not differ from the comparison group in their language and cognitive development, they did display significantly greater emotional and behavioral problems.
Haskett, Miller, Whitworth & Huffman (1992)	Infants and young children can be extremely difficult to care for and manage due to the medical and behavioral outcomes from prenatal exposure to crack.
Chasnoff, Griffith, MacGregor, Dirkes & Burns (1989)	The birth weight of babies affected by cocaine is lower than that of their normal counterparts.
Chasnoff, Burns, Scholl & Burns, 1985 and Griffith (1988)	Both studies found depressed interactive behavior and poor state control among babies affected by cocaine.
DHHS Office of Inspector General (June 1990)	Prenatal exposure to crack can lead to premature birth, low birthweight, birth defects, and respiratory and neurological problems. These babies also have a significantly higher rate of SIDS.
Woods, Plessinger & Clark (1987)	Cocaine use during pregnancy causes uterine vasoconstriction, decreasing oxygen and nutrients to the fetus, thereby causing poor fetal growth.

### **Effects of the Environment**

Some researchers have begun to pay greater attention to the effects of the postnatal environment on drug-exposed children's subsequent development (Zuckerman & Bresnahan, 1991). Children who have been exposed prenatally to narcotics (e.g., heroin or methadone) have been found to suffer adverse developmental outcomes only when they were also exposed to such environmental risk factors as poverty or a poor-quality caregiving environment (Hans, 1989; Lifschitz, Wilson, Smith & Desmond, 1985).

Ards and Mincy (1994) paint a dismal picture of the environment in which children must live as they grow. Not only must these children cope with their mother's use and its possible physiological effects on them, they also most commonly live in neighborhoods saturated by drugs, crime, and deep poverty, where families are isolated and supports are few.

Delattre (1994) describes drug-addicted parents and their children, noting that some children as young as 10 and 11 are turning from victims into victimizers. Delattre points out that children learn much by example, and that the neighborhoods where they live encourage them to rely on impulse and violence to get their needs met. Ratings on the Achenbach Child Behavior Checklist (CBCL) (Achenbach, 1988), a standardized measure of such problems, show that caregivers in a National Association for Perinatal Addiction Research and Education (NAPARE) study (as cited in Hawley et al., 1995) rated cocaine-exposed children as more aggressive than non-exposed children at age three.

# THE EFFECTIVENESS OF CURRENT SERVICES

## **Difficulties in Evaluating Services**

We have not carefully defined our terms regarding drug abuse and drug treatment. This confusion is one of the factors making it difficult to form conclusions about the effectiveness of treatment. We have different models for understanding addiction. We have different types of treatment, with different goals. We have few programs specifically designed for female crack users. We have trouble engaging these women. We have almost no long-term data on the effectiveness of the programs that we do have.

## **Confusion About Models of Addiction**

Some of us use a medical model that stresses genetic factors, the addictive properties of the drugs, central nervous system changes, and the use of drugs to self-medicate. Others of us prefer a behavioral model that focuses on the reinforcement aspects of the drugs, as well as classical conditioning of drug use to environmental cues. Still others emphasize a social model that involves drug availability, peer pressure, and social stress. Others combine all these into the biopsychosocial model. These differing methods of conceptualizing problems lead to different hypotheses of change and different methods of intervention. Table 3 (see page 18) presents a summary of the most common conceptual frameworks for models of addiction.

## **Confusion About Definitions of Drug Treatment**

The label *drug treatment* encompasses a collection of programs with very different orientations, objectives, staffs, settings, procedures, and participants. Research on one program may have little relevance for another.

Gerstein and Harwood (1990) identify four major types of drug treatment:

**Outpatient methadone maintenance:** These programs are aimed at heroin addicts and involve daily doses of methadone to produce a stable physiological state with alleviated opiate cravings.

**Residential therapeutic communities:** These approaches typically involve 9 to 12 months of participation in a structured setting that blends resocialization, milieu therapy, and behavior therapy. Often they involve occupational training and graduated levels of responsibility before reentry to the community.

**Outpatient non-methadone treatment:** The programs vary in their processes, philosophies and staffing. Usually, people attend for one or two visits a week for individual or group therapy for an average of six months.

**Inpatient chemical dependency treatment:** This usually involves three to six weeks of residential or inpatient help and use of a 12-step model of personal change. Daily educational lectures are combined with small task-oriented groups and other services.

**TABLE 3**  
**Models of addiction** (adapted from Marlatt & Gordon, 1985)

<b>Model of Addiction</b>	<b>Conceptualization of Problem</b>	<b>Hypotheses of Change</b>	<b>Method of Intervention</b>
Medical or Disease Model	Addiction is a genetically predisposed, chronically relapsing illness that is triggered when the drug is consumed, resulting in addictive behaviors and lifestyle.	A chronic relapsing condition cannot change for the better on its own. By accepting the diagnosis and entering treatment and never touching the drug again, the condition can go into remission.	Interventions include total abstinence, hospital treatment programs, total lifestyle change, 12-step programs, confrontation, and group conformity.
Behavioral or Social Learning Model	Addictive behaviors are overlearned, maladaptive habit patterns.	Addictive behaviors can be analyzed and modified so one can get control over the addiction.	Interventions include a choice of moderation or abstinence, outpatient treatment programs, behavioral coping skills, cognitive restructuring, education, and skill building.
Biopsychosocial Model	Addictive behaviors are the result of many factors, some genetic and some learned.	In order for change to occur, all aspects of the etiology and the effects of the addiction need to be addressed.	May make use of any of the above interventions. What is most important is that different types of treatment work for different people at different stages of their addiction.

Some differences cut across the major categories. Some programs focus on illicit drug use and criminal activity, while others target the overall functioning of clients. Some insist on abstinence, some assist people in getting control of their drug use. Some employ professionals, others use ex-addicts.

Two other groups Gerstein and Harwood do not speak to are:

**Independent self-help groups:** Groups such as Narcotics Anonymous and Cocaine Anonymous can include many of the same components as the above categories.

**No treatment/No self-help groups:** To make matters even more confusing, researchers have known for decades that

many people get off drugs on their own, without treatment or self-help groups. For example, Brown, Hickey, Chung, Craig and Jaffe (1988) observed large reductions in drug use among drug abusers waiting one to six months to enter cocaine treatment.

**Effectiveness of Current Programs**

For the purpose of this paper, we are most interested in approaches that appear to be helpful for women on crack, both at the programmatic level and at the individual level. We have very little empirical data regarding the effectiveness of particular models for this population (Wallace, 1991c). There are no figures available on the long-term effectiveness of residential crack treatment programs



for women (Nunes-Dinis and Barth, 1993). Many innovative treatment programs for pregnant mothers or for inner-city minority compulsive crack smokers lack a formal evaluation component (Inciardi, Lockwood & Pottieger, 1993). Almost nothing is known about the effectiveness of chemical dependency treatment or non-methadone outpatient treatments as a group (Apsler, 1994).

In one of the few projects with evaluation data, Howard (1994) discusses her results from Project Pride, an early intervention project for drug-abusing mothers and their children in Los Angeles. Staff visited mothers once a week for 90 minutes for the first month, then biweekly for the remainder of the program.

Most of the mothers in the program continued to use drugs despite efforts by the program staff to help their clients identify, enter and stick with drug treatment. Only 15 percent of the mothers remained abstinent for one year.

Among mothers who did not abstain from drugs, even high-quality, intensive early intervention services were not able, over time, to raise parenting skills to a level where the care provided was both stimulating and nurturing. Fully 100 percent of the children of heavy drug users exhibited insecure attachments to their mothers, compared to one-third of the children whose mothers did not use drugs.

One other program with some empirical data shows more promise. The Center for Perinatal Addiction at Northwestern Hospital in Chicago includes prenatal medical care, pediatric follow-up, social service case management, chemical-dependency treatment on-site, an interdisciplinary staff, parent education, support groups, and the use of community outreach (Kronstadt, 1989). In this program, 79 percent of mothers were still off drugs one year after giving birth (*New York Times*, p. A14, Aug. 7, 1989).

## Why Women Don't Get Treatment

### Estimates of inadequate supply of treatment

**options:** Estimates of the proportion of the substance-abusing population who are women range from 30 percent to 50 percent (Kravetz & Jones, 1988; Pape, 1993; Van Den Bergh, 1991), while only 14 percent to 19 percent of clients in treatment for substance abuse are women (Turnbull, 1989; Mondanaro, 1989; Van Den Bergh, 1991).

A 1990 survey by the National Association of State Alcohol and Drug Abuse Directors, Inc. (NASADAD) found that an estimated 280,000 pregnant women nationwide were in need of drug treatment, yet less than 11 percent of them received care (Drug-Exposed Infants, GAO, 1990). The Institute of Medicine (1990) estimates 30,000 pregnant women receive drug treatment annually, while an estimated 105,000 need it. Other studies estimate that 4 million women need treatment for drug abuse (NIDA, 1995).

### Fewer women are identified as needing treatment or are encouraged to enter:

One of the reasons relatively few women enter treatment is that, compared with men, fewer women are identified as needing treatment or are urged to participate in it. Many men are identified and enter treatment through encouragement from their spouse, drunken driving arrests, or coercive intervention from work. For many women, these points of intervention do not exist (Mondanaro, 1989). They are more likely to be with chemically dependent partners and less often confronted and urged to seek help by family members (Kagel, 1987).

Women substance abusers are less likely to be in job positions with enough status that their employers might pay for treatment. More often, they have no health insurance and are just replaced (Mondanaro, 1989). Women are more likely than men to encounter opposition to treatment from friends and families. Women are also less likely to be

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*The label "drug treatment" encompasses a collection of programs with very different orientations, objectives, staffs, settings, procedures, and participants.*

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*They are  
afraid of  
losing  
their  
children.*

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identified and referred for treatment by professionals, including physicians and social services workers (Beckman & Amaro, 1986).

Women are more apt to seek help for other problems, such as depression.

Therefore, they are over-represented in the mental health system, where they may be incorrectly diagnosed, and under-represented in substance abuse programs (Mondanaro, 1989).

**They do not want to confront the negative stereotypes and stigma attached to the drug addict label:**

One reason women fail to enter treatment is that they are reluctant to confront stereotypes about addicts. Though the image of male crack abusers is certainly negative, the image of female crack abusers, especially mothers, is worse. Such a woman is not only deviant, sick, sneaky, and virtually hopeless like her male counterparts; she is also unfeminine, promiscuous, and unfit to be a mother.

Drug abuse is often viewed as a moral issue. Substance-abusing women can be viewed as sexually promiscuous, weak-willed,

negligent of their children, and irresponsible in their decisions to bear more children (Finkelstein, 1993a, 1993b; Kumpfer, 1991; Mondanaro, 1988; and Sandmaier, 1992).

Many of these women believe, as society does, that they are terrible people and bad mothers (Finkelstein & Derman, 1991).

Because of these stereotypes, women try harder to hide their abuse problems (Pape, 1993; Turnbull, 1989) and therefore are not as likely to be identified as abusers.

**They are afraid of losing their children:**

Women also hesitate to identify themselves as needing treatment because they fear they will lose their children if they do. The literature reveals that from 40 to 70 percent of women in drug treatment have children (Mondanaro, 1989).

Lack of child care is a related problem.

If women are assigned to inpatient treatment or intensive outpatient treatment, the lack of child care means giving up the children to get treatment. This is a choice many women will not make.

Lack of child care and fear of losing children are frequently cited barriers to substance abuse treatment for women (Mondanaro, 1989; Kravetz & Jones, 1988; Turnbull, 1989; Pape, 1993; Kagel, 1987; Segal, 1991; Van Den Bergh, 1991).

# A M A P F O R D E V E L O P I N G M O R E E F F E C T I V E S E R V I C E S

## **Introduction**

Although we have few examples of well-documented, effective programs for women on crack, there is remarkable consensus about which strategies are most promising at the systemic level, the model level, and at the worker-mother level. In this section, we offer principles and examples of ways to build a response in relation to what has been learned about crack-abusing women in the last decade.

We hope to provide a map, a structure, for applying what we know about problems and strategies of human behavior; principles applicable to all areas of human services, including drug treatment. This map, or structure, will be divided, at times somewhat arbitrarily, into three related areas: systems change, model and program design, and frontline practice.

## **Systems Change**

Particularly at the systems level, options for modifications of the way we do business can seem unlimited and overwhelming. The following is certainly not an exhaustive list of possibilities, but it is one way of structuring some alternatives for policymakers who feel responsible for overall, dramatic fundamental change in human services.

### **Acknowledge the Scope of the Problem**

As child welfare services policymakers, we need to acknowledge that this problem is not going to go away. Drug treatment programs are not going to be available to handle all the mothers who are now being referred to child welfare.

We also need to acknowledge that the millions, perhaps billions of dollars necessary to provide new, ideal treatments for all those who need it will not be forthcoming. We need to come to grips with the fact that we will have to make much better use of the resources we have now, rather than expecting and waiting for additional pots of money.

### **Take Heart: Become Familiar with Data About Approaches and Techniques That Look Promising**

Obtain and analyze state and local data about what is happening in your area. Although formal, published, empirical data about models that work are sparse, many state and local groups do have informal, usually unpublished data on women and crack and what strategies have been helpful. This, along with data from the national scene, should be considered in planning.

This is another area where our personal experiences with drug and alcohol abuse tend to make each of us feel like an expert. We need to acknowledge that we are not experts, and to conduct systematic reviews of information, rather than focusing on personal anecdotes or party lines not substantiated by documented positive outcomes.

Regardless of how frustrated people are with this problem, they are coping. Day to day, workers see people with drug problems and many are able to be helpful. We need to collect examples of what is working. We need to identify and capture

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*One reason women fail to enter treatment is that they are reluctant to confront stereotypes about addicts.*

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all the energy any one of us has for working on this topic. If you can't find any, get some consultation on how to begin. Ask your colleagues what is working and what system-level changes would make things better.

### **Acknowledge That No Silver Bullet Exists**

Realize that no one prototype will work for every system or community. Each worker will have to decide personally what makes sense to prioritize and evaluate in each local area.

### **Clarify Your Values and Philosophy About Drug Abuse**

Because of the confusion about models of conceptualizing addiction, because of our own personal experiences with drugs and alcohol, and because of competing and confusing societal messages about drug abuse as a moral or a health issue, we start at a disadvantage for good problem-solving. It's worth it to take the time to talk these issues through, until both individuals and groups can clarify what they think, what they value, and what they would like to achieve in relation to the crack problem.

Take the time to clarify what you already know about drugs and drug-affected families. What are your values in this area? What are your thoughts about how people change? How does your perspective mesh with the data, experiences, and biases of others?

### **Take Action Now**

Hundreds of thousands of children are now affected by parental drug abuse. We cannot wait for definitive answers or guarantees that certain courses of action will promise success. We have to begin to use what we do know and begin to put it into action immediately.

### **Make a Plan**

Allow time to systematically identify and evaluate options for proceeding. Do we want to start with small, specific changes, or make sweeping policy changes? Do we want to

train workers or develop new models? Do we want to have case managers? Specialists? Teams? Generalists?

Take the time to make a detailed plan about the steps you want to take. Expect challenges such as anxiety and confusion over new roles for everyone, union expectations, problems like needing auto insurance for neighborhood workers, and relapses by both staff and families. Make sure you get feedback regularly so you can address problems as they arise.

### **Form New Partnerships**

At the systems level, we must forge new partnerships and develop new roles that allow us to assemble more coordinated, encompassing forms of help so that we might have a comprehensive approach addressing biological, psychological, and social realms (Wallace, 1991c).

Identify people in your area who really care about the drug issue. Get them together to talk. Reach out to new partners in non-traditional settings and roles, as well as other systems like health, education, drug treatment, mental health, and housing. Take the time to listen to one another. Don't be afraid to dream about how things might be, even if you know there are obstacles to those dreams.

### **Try New Service-Integration Strategies**

According to Wallace (1991b), programs for crack cocaine addicts must be intense and comprehensive to be effective. She refers to the research by Kleinman, Woody, Todd, Millman, Yang, Kemp and Lipton, that tells us that the characteristics of programs, their structure, intensity, and comprehensiveness, may be a better determinant of patients' success in treatment than the characteristics of the clients themselves. Their largely African-American cocaine-dependent population needed the same kind of intensive and comprehensive treatment that has worked (Washton, 1986; Rawson et al., 1986)

with cocaine patients of diverse demographics (p.183). Many interventions may have been ineffective not because women on crack are beyond help, but because we have tried to attack complex, deeply rooted problems with isolated fragments of help that focus on personal characteristics but do not take into account the impact of family, community, or environmental factors.

Certainly we cannot afford to provide all the help that various experts would like to see, and certainly all services are not necessary for all women. We do, however, need to begin planning for ways to guarantee access to a wider range of help than is currently available.

We need to consider new, non-stigmatizing entry points for people on drugs, like hotlines or drop-in centers, battered women's shelters, or neighborhood centers. We cannot force entry only through formal drug treatment points.

We can go beyond making referrals to other systems and learning each other's names. We can have cross training, co-location of servers, blended services, or one-stop shopping (Zuckerman, 1994).

We can also think about approaches as collections of supportive components, so we can assemble unique combinations for each person and family.

We can consider having a relatively small number of professionals and paraprofessionals provide all the services, so that families are not overwhelmed by having to deal with many helpers in many sub-specialties.

We can also think about approaches as collections of supportive components, so we can assemble unique combinations for each person and family. We can allow people to take part in pieces of various programs rather than having to accept all or none. We can design approaches that offer help outside regular work hours and in a variety of locations.

### **Shift Funds as Necessary**

As we attend to research and other systematic gathering of information, we will be forced to acknowledge that some approaches appear more effective than others. Since it is unlikely we will get additional funding, dollars will have to be shifted from one approach to another. We can't afford to do everything. We will have to make some hard decisions.

### **Remove Specific Barriers**

**Outreach:** Because of the past stigma and lack of relevance of some drug treatment programs for women, we must make an active effort to connect with the women where they are, on their terms. Some of these efforts must include hotlines and drop-in centers (Halfon, 1989; Kronstadt, 1989; McRobbie et al., 1990).

### **Reduction of stereotypes and stigmas:**

We must make certain that those who provide help can do so with compassion rather than with contempt or scorn that can drive women away.

**Ongoing support:** We need to provide continuing encouragement for women on crack to enter and remain in pathways for change (NIDA, 1994).

**Access to children:** Most women on crack are motivated by hope of retaining or regaining access to their children. Regular contact between biological mothers and their infants in foster care can help maintain treatment involvement (Halfon, 1989; Kronstadt, 1989; McRobbie et al., 1990).

### **Build in support and encouragement for yourself:**

Keep telling yourself you don't have to do everything all at once. A step in the right direction is a step in the right direction. If you can take one small step each week, you will make progress.

Schedule regular, even short, telephone calls or in-person meetings with people who believe in you. Talk with a family one of your

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*We have very little empirical data regarding the effectiveness of particular models for this population.*

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workers has helped. Find others with similar goals who will pat you on the back when you succeed, and commiserate when you don't.

## **Model Development**

### **Build on Strengths**

Study the programs and people who are doing better than others in addressing drug issues. Ask your workers how the structure in which they work needs to change for them to do as well as they might. Ask the families how they would like your services to change.

### **Allow for Individual Tailoring**

We need to provide help and support that will fit the needs and wants of unique women, rather than fitting crack users as a group. As Wallace (1990a) points out, Findings indicate that crack smokers are not a monolithic group, and no simplistic prescription of a single treatment is possible. The data reveal the tremendous diversity to be found within a sample of compulsive crack smokers, highlighting the need for carefully assessing and matching patients to treatments of appropriate intensity that effectively meet their individual treatment needs (p. 117).

As we recognize that women on crack may best be helped with a wide range of entry points to various types of help, we must design systems that respond to the needs of each particular individual. Let's not waste resources by requiring everyone to have the same type of help whether or not it is useful.

We need to ask not "What works?" but "What works for whom?" (Wallace, 1991c). We can use and encourage women to use comprehensive assessment methods that scan all life domains. The Center for Substance Abuse Treatment (CSAT) (1994) agrees, recommending that the treatment plan address the specific needs of each client rather than relying on a standardized form.

## **Use a Holistic Approach**

Develop as wide a menu as possible for help. See if you can include the following, and more, in this menu:

**Provision of basic needs:** NIDA (1994) recommends comprehensive services for women, including food, clothing and shelter, medical care, and transportation. CSAT (1994) recommends a model of comprehensive services, including health care. Medical care should include outreach to pregnant women, prenatal care, pediatric care, obstetric services, developmental and emotional assessment of the infant, and provision of clinical interventions for infants (Halfon, 1989; Kronstadt, 1989; McRobbie et al., 1990).

### **Pharmacological and nutritional support:**

Medications that reduce intense cravings are part of a multidimensional approach (Wallace, 1990c). Rosecan and Nunes (1987) suggest using medication and amino acids that reverse the chemical imbalance created by crack.

Blum and colleagues (1988) found that a nutritional supplement or pharmacological adjunct called Tropamine (Matrix Technologies, Inc.), given to patients (n=54) in a 30-day hospital treatment program during an open trial, reduced drug craving or drug hunger significantly in comparison with controls. It also reduced the severity of the cocaine crash. Tropamine appears very promising: it permitted 95.8 percent of patients to manage drug hunger and complete inpatient detoxification, compared with 62.5 percent of controls.

Bromocriptine also worked to alleviate withdrawal symptoms (Herridge & Gold, 1988). Gawin (1989) reports promising preliminary work with flupentixol: nine of ten patients reported that their cravings for crack were ameliorated within three days and their depression lessened. Trachtenberg and Blum (1988) note that the combined use of amino acids and imipramine appears more effective

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*Realize  
that no  
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community.*

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than an antidepressant such as desipramine alone. Rosecan and Nunes (1987) recommend that cocaine abusers take L-tryptophan and L-tyrosine to promote biosynthesis and restoration of depleted neurotransmitters.

**Acupuncture:** Michael O. Smith, Medical Director of the Substance Abuse Division, Department of Psychiatry at Lincoln Hospital in New York City, views acupuncture as a well-established treatment of choice for early retention of relatively non-compliant substance abusers, particularly abusers of crack cocaine (NADA, 1993). Lincoln Hospital has been using acupuncture as part of its drug treatment program since 1974, with positive results. According to Smith (1989a), acupuncture provides a foundation for psychosocial rehabilitation and should be part of a program that includes counseling, a drug-free contract, educational and employment referrals, and group involvement. Smith explains that acupuncture controls withdrawal symptoms and craving and also reduces fear and hostilities that tend to disrupt drug-treatment settings.

Many other drug treatment studies credit acupuncture with positive outcomes. The Drug Court Diversion program in Miami, Florida found that acupuncture established an excellent rate of treatment retention for drug possession felony arrestees (Smith, 1993). Other programs have duplicated the Miami work (based on Smith's Lincoln hospital protocol) with promising results (Smith, 1993). Studies focusing on crack cocaine have also had good outcomes. Chao (1989); Smith (1989a, 1993); American Hospital Association (1991); and Lipton, Brewington and Smith (1994) report that acupuncture seems to reduce craving, permits crack mothers to provide urine samples free of cocaine, and can increase treatment retention.

**Help in coping with past trauma:** High proportions of women who seek treatment for addiction report incest or child sexual assault in their histories (Reed, 1991). Many studies

estimate that 30 to 75 percent of women in treatment for substance abuse have been victims of childhood sexual abuse and/or rape (Yandow, 1989; Bollerud, 1990). Kovach (1986) states that clinical reports suggest that without treatment, victims of abuse experience more difficulty in early sobriety and may be more vulnerable to relapse. It is estimated, though, that fewer than 20 percent of treatment programs offer specialized services for abuse victims (Yandow, 1989).

**Development of a new sense of self:**

CSAT (1994) recommends that a treatment program addressing the above areas should also consider spiritual needs. Turnbull (1989) recommends that issues related to low self-esteem, dependency, learned helplessness, sexual matters, and traditional sex role socialization be a part of a treatment program for women.

**New ways to handle emotions:** Women often connect the onset of their problem drinking and drug use to a specific stressful event, including divorce, desertion, infidelity, death of a family member, child leaving home, postpartum depression, gynecological problems, and menopause (Reed, 1991; Pape, 1993). Depression is one of the most frequently hypothesized antecedents of female alcoholism in the literature (Boyd, 1993).

Relapse prevention for women needs to address the stress-inducing circumstances to which women may attribute the addiction, and the relative lack of social and occupational resources that may preclude an improvement in environmental support for recovery (Chiauszi, 1991).

**Sense of hope, safety, and competency**

**regarding the future:** Substance abuse in women seems to be heavily influenced by environmental factors (Pape, 1993; Reed, 1991). Haskett et al. (1992) found that one of the most important factors in predicting

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*As child welfare services policymakers, we need to acknowledge that this problem is not going to go away.*

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a positive response is the quality of the environment in which clients live after release from an inpatient treatment program.

Sutker (1981) states that 72 percent of women completing federally funded treatment continued unemployed and lacked necessary skills to get or keep a job. Job counseling and training, legal assistance, literacy training, and educational opportunities are also recommended.

Table 4 presents a summary of an ideal menu of supports for drug-abusing women.

*Develop as wide a menu as possible for help.*

**T A B L E 4**  
**Program features that may be helpful**

<b>Program Features</b>	<b>Description</b>
Meeting Basic Needs	Comprehensive services including food, clothing, shelter, medical care, and transportation will go a long way in establishing rapport and keeping women from being distracted by unmet basic needs.
Pharmacological and Nutritional Support	Medications that reduce intense cravings can help women stay in treatment.
Acupuncture	Acupuncture has been shown to reduce cravings and can increase the effective period of the treatment.
Help in Coping with Past Trauma	Addressing past traumas such as sexual or physical abuse and domestic assault may decrease vulnerability to relapse.
Development of a New Sense of Self	Maintaining the drastic lifestyle changes entailed in stopping drug use requires development of a new sense of self. Addressing spiritual poverty, low self-esteem, dependency, learned helplessness, sexual issues, and traditional sex-role socialization can help women with this process.
New Ways to Handle Emotions	Because of the relationship between depression, stressful events and use of substances in women, it makes sense to teach new ways to handle emotions.
Sense of Hope, Safety, and Competency Regarding the Future	Educational counseling, job preparation, training, and support can give women a sense of competence and hope for the future.
Access to Children	Regular contact between biological mothers and their infants in foster care can help to maintain treatment participation.



### **Developing a Wider Range of Drug Treatment Options**

Residential programs of alternative lengths and formats are clearly needed as reasonable cost options for an already overburdened foster care system (Barth, 1993; Feig, 1990). Washton (1989) and Rawson (1990) argue that intensive participation (4 to 5 days per week) in an outpatient rehabilitation program offering comprehensive services (urine testing, individual counseling, family education, family therapy, couples counseling, relapse prevention, and 12-step groups) may be preferable and more cost-effective than inpatient treatment.

### **Developing a Wider Range of In-Home Options**

Richard Barth (1994) recommends that we develop the capacity to provide long-term supervision in the home, and long-term supportive services for all family members. Barth discusses current practices that provide very short-term services, end them, find re-abuse rates of 30 to 40 percent and repeated drug-exposed births, then reopen the case and begin all over again. Long-term, in-home support would be more humane and less costly than current policy.

### **Developing a Wider Range of Out-of-Home Placement Options**

Ideally, our programs will become so strong that termination of parental rights is largely unnecessary. Until this is the case, the disadvantages of terminating parental rights can be buffered, if not largely eliminated, by maintaining family ties to the extent that they are positive for the child.

**Shared family care:** Many experts recommend gradations of out-of-home care. Barth (1994) discusses shared family care, including a wide range of methods for supplementing parental capacity. Parents and host caregivers may share the care of the child and work toward independent in-home care by the parent. A pregnant mother might be in a

group home with other pregnant mothers. Foster care might include both mothers and children. Cluster housing or supervised living arrangements might help groups of drug-affected women and their children. In Los Angeles, the Adopt a Family program recruits community volunteers to support vulnerable families. In Sweden, the Contact Family Program involves paying a family a modest stipend and reimbursement for travel to provide weekly contact and one weekend a month of care for children in a vulnerable family. If the mother is unable to care for her children, the Contact Family acts as emergency foster parents and cares for the children for as long as necessary.

**Kinship care:** In some states, kinship care has increased dramatically over the last few years, leading to the development of special services to assure appropriate placement, stability, and protection with relatives (Williams, 1994).

**Legal guardianship:** Where relatives are not available, legal guardianship is another alternative to adoption or limbo in foster care. Williams (1994) recommends that guardianship be considered for children cared for in family networks but who are without parents or legal guardians; children whose ties to their parents have been surrendered or terminated and who have not been placed for adoption; and children whose adoptions have been annulled and whose custody has returned to the public agency. She also recommends that guardianship be considered in situations involving parental incapacity or unwillingness to care for the child, or for children who are in placement and whose parents, although they visit regularly, are unable to provide 24-hour care.

**Deciding when to seek short-term and permanent custody:** If we had more options for ways to support birth families as a unit, or to let children keep in contact with parents who will never be able to parent alone,

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*Relapse prevention for women needs to address the stress-inducing circumstances to which women may attribute the addiction.*

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*Parents and host caregivers may share the care of the child and work toward independent in-home care by the parent.*

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admitting long-term parental incapacity would be easier. Ironically, our society, which frequently holds crack-addicted women in contempt, also grants them leeway in parenting that we do not accord women who are not using drugs. In some cases, we allow them many, many tries at treatment as their children bounce in and out of foster care. We may feel guilty that we do not have effective programs to help them. We may be confused by the idea that drug addiction is a disease, thinking we would not terminate parental rights if the mother had a more respectable terminal illness. As we work toward more successful help for women on crack, we must hold them accountable to the same standards of parenting as their non-drug-abusing peers.

Although the exact guidelines are not clear for the number of tries that are acceptable and the number of years a child may wait for his or her mother to achieve sobriety, we must begin to grapple with these issues.

Horn (1994) recommends expedited termination of parental rights and adoption if addicts abandon their children in the hospital. He believes these adults have clearly demonstrated their unfitness as parents, and that the chances of successful reunification are small (assuming that the parents can be located).

Wald (1994) struggles with the pros and cons of termination of parental rights. He believes there are three types of cases in which immediate termination should be authorized:

1. Situations in which a child under three years of age has suffered serious physical or sexual abuse;
2. Situations in which a child has been removed previously, good services were given to the parent, the child was returned home, and the child was maltreated again; and
3. Situations in which the parent is completely resistant to any treatment.

Wald also believes that we need guidelines for termination of parental rights based on the length of time that the child has been in placement—perhaps six months for children less than one year old, and 12 or 18 months for older children.

### **Changes at the Frontline Level**

At the frontline practice level, a remarkable degree of consensus exists about practices that are likely to be the most helpful. These strategies are supported by data on effective frontline practice in other human services systems. Workers and policymakers in a variety of contexts agree on principles that include building on strengths, a holistic approach, individual tailoring of services, decisionmaking partnerships, short-term specific goal setting, and attention to worker characteristics and skills (Kinney et al., 1994).

### **Worker Selection**

When people are not helped by services, we commonly assume that they are hopeless: unmotivated, in denial, or resistant to treatment. Numerous studies indicate, however, that worker characteristics and skills can override such factors in leading to productive change.

**Compassion and empathy:** Miller (1985) says that the most underestimated and least investigated determinants of motivation within addictive behaviors are therapist characteristics. He quotes Cartwright (1981): The repeated failure of studies . . . to find differences between experimental groups and control groups has usually been interpreted to indicate that treatments are themselves ineffective, and that patient characteristics are the most important determinant of outcome in the treatment of alcoholism. Few researchers considered the alternative that it is not the patient's characteristics which are of key importance, but factors concerned with the therapeutic perspective (pp. 351-353).

The ability to form a supportive, therapeutic relationship with the crack-addicted mother is essential to successful treatment. Because of all the buttons pushed when a worker is faced with a woman whose drug abuse is hurting her fetus and/or other children, it takes a strong commitment for a worker to be able to maintain an empathetic stance.

Washton (1989) and Wallace (1991b) both see the therapeutic relationship as the basis for influencing behavior. The way that clinicians relate to clients will determine their effectiveness. Washton urges us to give addicts permission to resist and be ambivalent, joining with patients around shared goals, instill trust and hope by conveying understanding, empathy, respect and confidence. Resistance is to be expected; it is the focus of the work, not an annoying distraction.

Wallace (1991a) also believes that helper characteristics strongly affect women's responses to help. She points out that the pregnant crack addict admitted to the emergency room or entering a treatment program may be hated and despised by staff members. Staff members may frequently ask, "Who is this cold arrogant monster who acts as though she does not need our services, acts superior to us, has done probable damage to her fetus, regularly engaged in prostitution, and may even be uncertain as to who fathered her child?"

Zuckerman (1994) thinks the best way to help frontline workers become more compassionate to women on drugs is to encourage them to speak at length with women in recovery. This can help the workers to view them as individuals, and to understand how much of their behavior has been shaped by misfortunes and tragedy.

Zuckerman also talks about the feelings of anger in many child protection workers when faced with women who use drugs heavily during pregnancy. He believes the anger is understandable, but if it is communicated to the mother, she may not trust the

practitioner and may not accept any help. He recommends that these workers approach addicted women with empathy and concern, emphasizing the possibility that, with treatment, a woman can improve the future for herself and her children.

Wallace's (1991a) research and experience with crack addicts has led her to believe that a therapist who can convey empathy, respect, and a genuinely caring attitude allows clients to develop the trust necessary to work with the therapist on recovery. She believes even the ambivalent crack abuser can be engaged in the treatment process, if therapist behavior during the assessment conveys the above qualities.

**Support vs. confrontation:** Many believe that the traditional confrontational model for substance abuse treatment is not as appropriate for women as for men. Workers who rely too heavily on confrontation can reinforce a woman's sense of powerlessness and further lower her self-esteem. Women appear to need a great deal of support in order to be willing to enter treatment.

One study indicated the need for varied approaches. Among women under 30 with higher self-esteem and more positive self-images, direct confrontation was used successfully. With women age 30 to 45 who had lower self-esteem, avoiding confrontation and stressing strong support groups was preferable (Pape, 1993).

**Resilience and perspective:** We must screen for worker tendencies that will be the most helpful, and we must also afford these people opportunities to refuel, to attend to their own balance and sense of well-being. Some public agencies are beginning to address these issues through workshops aimed at enhancing resilience (Kinney, 1995).

Certainly all who work frequently with women on crack need continuing opportunities to clarify their perspective and maintain both realistic concern and a sense of hope. The mindset about women on crack and

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*Workers... agree on principles that include building on strengths, a holistic approach, individual tailoring of services, decisionmaking partnerships, short-term specific goal setting, and attention to worker characteristics and skills.*

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*...child protection workers approach addicted women with empathy and concern, emphasizing the possibility that, with treatment, a woman can improve the future for herself and her children.*

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about drug-affected families in general that workers bring to a family will not only affect the way they describe the situation, but will also change the situation for better or worse.

We need to be able to understand and then set aside our personal frustrations about human services work in general, or our jobs in particular. Workers need a chance to evaluate their own transitions, values, meaning, and vision for ways that their situation could be better. They need to be encouraged to do their own survival planning and prioritize goals for maintaining morale. They need continuing opportunities to acknowledge the severity of the problems they face, and to help one another forge ahead.

The more that workers can go in with an attitude of openness, even with an expectation, that they will be surprised by people's capacity, the more likely it is that women on crack will be able to show their potential, and the more likely we will be to conclude that children will ultimately be safe in that environment. The dilemma is that we must also scan constantly for the risks as well as the strengths. It is this tension of balancing the positives and the negatives that makes our conclusions different when we see the same situations twice. It also shows that assessment is an art as much as a science.

In order to be fair in assessing drug-affected families, we also need to be clear about the personal stereotypes and experiences we bring to the task. How has substance abuse affected each of us? Why do people use drugs, anyway? What do they need to stop using them? Have we ever used drugs? Why? How might our own beliefs affect our ability to think clearly about families? How might our own experiences affect our ability to be effective? The more clarity we have on these issues, the more open we can be to feeling hope before we ever see a particular family, and the more families we will find to justify that hope. The more we enter a situation certain that we and the family will fail, the more likely it is that we will.

## **Worker Skills and Training**

Just as we need to look for and support workers who are compassionate, realistic, and optimistic, we need to train them for these new jobs. Several areas are critical.

**Keeping people safe:** We need to go beyond training in risk assessment to equip workers to do the best possible job of protecting children, families, and themselves. Over the past two decades, a body of technology for structuring situations to prevent violence has emerged from family support and family preservation practice. Training in these methods (Kinney & Nittoli, 1996) should be routine for all workers who bear responsibility for the hard decisions about children's safety.

**Ability to form decisionmaking partnerships:** People are better able to change when they have been involved in assessing the need for it, prioritizing issues to be addressed, and designing and developing plans for accomplishing that change. Decisionmaking partnerships facilitate change and enhance motivation in a number of ways:

- ❑ Self-attributed behavior change is maintained to a greater extent than is behavior change attributed to an external agent or force (Kanfer & Grimm, 1980).
- ❑ When people believe that they have responsibility for some action, that a successful outcome results from personal competence, and that the behavior is voluntary, motivation is enhanced (Kanfer & Grimm, 1980; Schunk, 1985).

Workers also need training in developing the best partnerships possible, even with people who are sometimes incapacitated by drug use.

Both Washton (1989) and Wallace (1991b) describe a kind of partnership between clinician and client that they see as most effective in work with crack addicts.

Washton likens the roles to those of a guide and climber. The guide keeps the climber moving on the right trail, points out the dangers, and provides basic tools and equipment. But the climber him/herself will have to take each and every step on the climb and exert his/her own energy and determination in order to reach the desired destination. (Washton, 1989, p. 96). The clinician can see her/himself as a consultant, furnishing alternative treatment recommendations and information about each treatment. The clinician will then have to keep in mind that the client has the responsibility to make the final decision.

On a practical level, we can encourage women to assess their own needs in relation to drug use as well as other areas. We can support them in identifying and obtaining resources they select from a menu of options. When we must require certain changes on their part in order to protect children, we can offer them choices about how to make those changes.

**Identification of strengths:** Capacities and resources can serve as building blocks for successful change. They can be resources for enhancing and maintaining motivation for that change by increasing a sense of self-efficacy. Acknowledgment of personal capacity encourages a person to form a relationship with the helper. It avoids self-fulfilling prophecies of doom about losers. It communicates high expectations for change. A focus on identifying strengths helps people identify their own strengths. It takes the pressure off the helper to have all the answers.

A CSAT (1994) publication on treatment for women who abuse substances includes identification of strengths and building a woman's self-esteem as part of an effective treatment program. Wallace (1991a) agrees that many crack addicts have very low self-esteem and feel shame, emotions deepened by what they may have done to get more crack. Low self-esteem must be addressed

in order for recovery to occur. Although many workers tend toward this strengths perspective naturally, few are able to build on strengths as systematically and routinely as they might. They need training.

It can be difficult to identify the strengths of a crack addict. A clinician often sees people with lives in shambles, suffering one bad consequence after another, but remaining in or returning to the crack culture. Without an understanding of the highly addictive nature of crack and an ability to transcend personal negative feelings, a clinician may only be able to see a weak-willed, arrogant, and selfish individual. If the client is pregnant or has small children, the clinician may only be able to see a child abuser. If these women and their families are to be helped, it is crucial that the helpers learn to identify them in terms of their strengths, and then help them to use those strengths.

Others acknowledge some strengths of some mothers addicted to crack. One study found that although addicted mothers might not be able to care for their children, they valued motherhood highly, tried to protect their children from the negative influences of crack cocaine and sometimes gave up their children voluntarily in order to protect them (Kearney, et al., 1994).

On a practical level, we can take many steps. We can use methods of assessing strengths such as those described in Cole, Day and Steppe (1994). We can use motivational interviewing to elicit energy for change. We can encourage talk about intentions, values, hopes, and dreams, as well as problems. We can point out strengths and resources these women may not realize they have. We can help them tap into the resources and energy of others who care for them, and we can enhance their awareness of others with similar problems who have reached goals that they share.

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**Assessment:** Workers need to know how to conduct a comprehensive assessment to determine the unique dimensions of a client's addiction (Donovan & Marlatt, 1988). Marlatt (1988) and Wallace (1991c) also recommend matching clients to treatments of appropriate intensity. Matching clients to specific treatments can be very cost effective. Not everyone needs 12 or 24 months in a treatment center. Some may not even need 14 days in detoxification or nine months in outpatient treatment. Involvement in a 12-step program alone may be enough for a few clients after initial detoxification or treatment.

Workers also need to understand how to integrate drug assessment for parents with risk assessment for children. We talk about assessing the risks of leaving children in drug-affected families as if there were some objective reality in each family that, if we had the right observation skills and the right assessment tools, we could know so as to make the right decision. No such infallible skills or tools exist. We cannot separate the facts of what is happening in a particular family from their context. Drug problems are related to societal, community, psychological, physiological, individual, spiritual, and other factors. When one aspect changes, the others change as well.

The final assessment of whether or not a child should be placed will also be influenced heavily by the tools and constructs we use to assess the situation. If we focus entirely on determining whether a parent is or is not an addict, we will come up with a very different assessment than if we use a holistic approach to the entire context of the family.

In determining the best living situation for a child, we also have to struggle for the right balance between broad patience in giving people every opportunity to show us their strengths and a realistic concern about their ability to care safely for their children. We have to realize that parents have many reasons for withholding information from

us. Drug use is illegal. It may result in children being taken. Enormous stigma is involved.

In general, the wider the lens we use to view a situation, the more accurate our overall impressions will be. We do need to focus on drug use, but we need to continue to assess other risk factors just as we always have. We must continue to pay attention to the same definitions of child abuse and neglect that we have used for years. We can still use the risk assessment tools that we have developed for families without substance abuse.

It is usually easy to see the value of placing a child elsewhere: drug-free caregivers, better daily routines, protection from most drug raids, better nutrition, usually a safer environment. While society commonly assumes that out-of-home placement is the safest alternative for many children, we need to recognize that it has risks as well. The child loses familiar surroundings, known history, belongings, pets, friends, schools, siblings, and family gatherings. We need to recognize these as losses and plan to restore as many as possible if we do feel that placement is needed.

Also, as discussed above, we need to note and remember the strengths of the birth family. Safety is relative. Just as we assess the risks and strengths in a birth family, we must examine them in the alternative placement we are considering.

Ability to set and monitor short-term, specific goals: Goal-setting and monitoring are important parts of successful interventions. Bandura and Schunk (1981), among others, have linked behavior-change effects of goal-setting and monitoring to increases in feelings of self-efficacy and motivation. Setting goals with clients allows both the helper and the parent to build on small successes that may trigger further changes (Friedman, 1992). It also builds expectation that change is going to happen and provides a way to measure the usefulness of the intervention (de Shazer et al., 1986). Workers particularly need help in learning to conceptualize and structure

small steps for women on drugs, as well as for themselves as providers of help. Nobody needs any more failures. We all need to set goals we can reach.

The substance abuse field has almost always used the long-term goal of complete abstinence to guide treatment. While it is an important goal, researchers now recommend using shorter-term goals because they appear more possible to the client and are therefore more motivating. For cocaine abusers, the desire to stop using must be translated into a specific plan of action. Washton (1989) believes, Giving up a drug-centered life is not just a mental exercise but an operational, behavioral task. We can help people to develop very concrete plans for one day at a time, and also for one hour at a time. We can practice recognizing and acknowledging the smallest successes, not only in relation to drug abuse but in other aspects of life as well. We can make more use of urinalysis and other physiological measures to monitor use and motivate compliance.

Short-term, specific goal-setting keeps the focus on objectives within reach rather than on abstinence for life, which seems overwhelming and impossible. Patients who succeed in achieving their first abstinence goal benefit from an early sense of reward and accomplishment. This builds positive momentum, bolsters feelings of self-control, counteracts defeatist attitudes, and reinforces other positive actions (Washton, 1989, p.104-105).

CSAT (1994) also sees the benefit of short-term goal-setting, pointing out that At intake, the treatment plan can address only the immediate problems presented by the client and observed by the clinical staff. In fact, some clinicians think it is inappropriate to set long-range goals at this point because the client may be concerned only about the immediate needs of herself and her family (p. 174).

Urinalysis is one powerful method for monitoring progress on drug-related goals.

Smith (1989), among others, argues for programs leasing urine-testing equipment and computerizing findings so that on-site results are available almost immediately. Smith further explains that daily urine tests and the resulting printout prevent therapists from having to play the bad cop role suspecting drug use or confronting patients without firm evidence, or anticipating urine results expected from an outside laboratory in several days or weeks. Daily results speak for themselves.

The use of contingency contracts in combination with urine testing has been reported as beneficial (Resnick & Resnick, 1986). What remains essential is checking urine several times a week if the contracts are to be effective. Even without a contract, Resnick and Resnick emphasize, urine testing remains crucial in order to undercut denial. A supervised urine sample should be taken every two or three days to verify abstinence and detect any unreported drug use. Urine testing establishes behavioral accountability for drug use and is seen by most patients as one of the most useful treatment tools in helping them achieve early abstinence (Washton, 1989). It prevents them from lying or from deceiving themselves, a comforting thought for most. It provides a backstop and an objective indicator of progress.

The cocaine treatment program developed by Rawson (1990) used random urine tests collected on a weekly basis. Full toxicology screens were used for about 10 percent of a client's tests, while the other tests were for drug(s) of choice only. This allowed for regular urine testing without the excessive cost of full screens. Readings that revealed drug use unreported by the client were used as points of discussion in therapy sessions. They provided an indication that some aspect of the treatment plan was inadequate or incomplete. Urine tests were not used for legal monitoring or punitive purposes.

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**Ability to enhance and facilitate motivation enhancement/empathic mirroring:** Wallace (1991a) advocates use of a technique she calls empathic mirroring to create cognitive dissonance and motivate clients to seek treatment. The clinician mirrors to the client the part of the client's inner self that experiences pain over loss of an infant or child to others custody, and her guilt about loss of control over continued drug use despite her knowledge of the destructive and negative consequences. The therapist empathizes with that inner self and may then be able to harness the mother's motivation to regain child custody. Wallace concludes with a description of her own clinical experience:

Although they appeared hardened and driven by their crack addiction, and utilized defenses to appear arrogant, aloof, and even braggadocious regarding their exploits in battle, they were actually the most fragile and vulnerable of souls, needing my empathy and forcing me to further improve my clinical skills. I discovered that empathic mirroring and achieving accurate empathic attunement to their pain, shame, humiliation, and guilt afforded an essential treatment strategy p. 276.

Miller and Rollnick (1991) and colleagues have amassed a substantial body of work supporting this approach, which they call

motivational interviewing. Workers can learn these methods. Women on crack will be more likely to succeed in getting off drugs if the workers have these skills.

**Relapse prevention:** Almost no one expects women on crack to get off and stay off the first time they try. Relapse Prevention, by Alan Marlatt and Judith Gordon (1985), remains the seminal and most encompassing document on relapse prevention methods. These methods are now being used effectively, with some tailoring, for women on crack. The most effective ones incorporate a variety of behavioral, cognitive, educational, and self-control techniques because of the many determinants of relapse (Wallace, 1992).

Since 1985, the form of psychotherapy most often used in the treatment of ambulatory cocaine abusers at the Yale Substance Abuse Treatment Unit is an adaptation of Marlatt and Gordon's work.

Detailed, concrete training materials are available on several subjects: addressing ambivalence, reducing availability of drugs, identifying high-risk situations and developing coping strategies for them, overcoming conditioned cues and cravings, recognizing the role of apparently irrelevant decisions, and modifying one's overall lifestyle. Although we have traditionally thought of these techniques as belonging to the drug treatment field, there is no reason they cannot be learned by child welfare workers as well.

Table 5 presents desirable skills for workers responsible for children of drug-affected women.

<b>T A B L E 5</b>	
<b>Essential worker characteristics and skills</b>	
<b>Characteristics and Skills</b>	<b>Training Needed</b>
Compassion and empathy: A worker who can convey empathy, respect, and a genuinely caring attitude allows women addicted to crack to develop the trust necessary to work together on recovery.	Encourage staff members to speak at length with women in recovery. This can help them view these women as individuals, and to understand how much of their behavior has been shaped by misfortunes and tragedies.
	<i>(continued on next page)</i>



**TABLE 5** (continued)  
**Essential worker characteristics and skills**

**Characteristics and Skills**

Support rather than confrontation: Workers who rely too heavily on confrontation can reinforce a woman's sense of powerlessness and further lower her self-esteem. Women appear to need a great deal of support in order to be willing to enter treatment.

Resilience and perspective: The more that workers go in with an attitude of openness—even an expectation that they will be surprised by people's capacity—the more likely it is that women on crack will show their potential.

Ability to keep people safe: Workers can be equipped to do the best possible job of protecting children, families, and themselves.

Ability to form decisionmaking partnerships: A worker who can form decision-making partnerships can facilitate change and enhance motivation.

Ability to identify strengths: A worker can identify a woman's strengths that can serve as resources for enhancing and maintaining motivation for the needed change.

Assessment skills: Workers can learn to make decisions that relieve their concerns about the safety of children.

Ability to set and monitor short-term specific goals: A worker can help women translate the desire to stop using drugs into a specific plan of action.

Ability to enhance and facilitate motivation enhancement/empathic mirroring: A worker can help create cognitive dissonance and motivate clients to seek treatment.

Relapse prevention skills: A worker can help women incorporate a variety of behavioral, cognitive, educational, and self-control techniques to prevent relapse.

**Training Needed**

Motivational interviewing skills, strengths-assessment tools, and tools to enhance feelings of self-efficacy can give workers the ability to rely on support more often and confrontation less often.

Agencies should take time to examine workers' perspectives, values, and beliefs about drugs, their clients, and their hope for their clients' recovery. Address these issues through workshops aimed at enhancing resilience (Kinney, 1995).

Learn about technology for structuring situations to prevent violence that has emerged from family support and family preservation practice (Kinney & Nittoli, 1996).

Learn how to hold the line on child safety while still facilitating a mother's decisionmaking in other areas by building rapport, developing menus of options and using motivational interviewing techniques.

Use methods of assessing strengths such as those described in Cole, Day and Steppe (1994).

Learn to use a wide lens to view a situation, looking at the many levels of risks of leaving a child in a home, as well as at the many levels of risks from removing that child.

Workers can learn to conceptualize and structure small steps for women on drugs, as well as for themselves as providers of help.

Learn about motivational interviewing (Miller & Rollnick, 1991) or empathic mirroring (Wallace, 1991).

Learn relapse prevention strategies (Marlatt & Gordon, 1985; Wallace, 1990b).

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*Short-term, specific goal-setting keeps the focus on objectives within reach rather than on abstinence for life, which seems overwhelming and impossible.*

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*We need to form partnerships with drug treatment programs so that we can make full use of options that are acceptable and helpful to women...*

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### **Ongoing Support**

Build continuing support for workers into your budget. Make sure approaches allow this support after hours as well as during regularly scheduled work times. Build in regular urinalysis for drug-addicted women, so that workers will not have to guess or play detective in trying to find out what is being used.

### **Conclusions**

#### **Assumptions**

Drug abuse is an extremely complex issue involving economic, environmental, racial, legal, familial, and individual physical and psychological factors. These are compounded by workers personal experiences with their own or others drug and alcohol use. All aspects interact with one another over time, further increasing the complexity.

Since the factors are interrelated, one can argue that it doesn't matter where we begin. As we change one factor, others will be influenced. Our best chances for success will occur if we use the strengths and motivation inherent in any situation to tailor a unique approach.

As we begin to plan and to develop new approaches, we should make use of existing experimental data on the effectiveness of systems, models, and techniques. In situations where data is not yet available or relevant, we should collect and use opinions of experts in the field.

#### **A Strong Child Welfare Response**

The strongest human services response will involve changes at the systemic, model, and worker levels. Current data would suggest the following:

**Changes in the system:** We need to acknowledge that many women with drug problems will not participate in what is currently thought of as drug treatment. We must improve our ability to address their drug problems as they enter other systems

as well, including child welfare, health care, and domestic violence and parenting programs. We need to form partnerships with health care providers regarding general health care for both parents and children whose health may be compromised by and partially causing some of the drug use. Data indicate that certain medications and nutritional supplements (such as imipramine, desipramine, lithium, tiropramine, bromocriptine, flupentixol, and certain vitamins) hold much promise for reducing urges and stabilizing emotions. Acupuncture looks promising. Detoxification is an issue for some women in some situations. Urinalysis can not only give everyone an accurate picture of drug use but can also help motivate people to avoid drugs.

We need to form partnerships with drug treatment programs so that we can make full use of options that are acceptable and helpful to women, and so that we can share what they and child welfare providers are learning. We need to form partnerships with self-help groups and neighborhood efforts. Women with drug problems need continuous support where they live.

**New models:** The ideal models need to be holistic, providing or facilitating ways to fill a wide range of needs: for basic life elements of food, shelter and transportation; employment; child care; mood management; spiritual resources; social skills; and parenting.

Services should be individually tailored to address each individual and family. They should be delivered in the environment where the problems are occurring and where a new lifestyle must eventually be in use seven days a week, to ensure the safety of children and to take advantage of the motivation elicited by crises.

At the beginning of involvement, most families should have access to at least ten hours per week of structured support. The amount may taper off over time, but for most families, some formal support will be necessary for one to three years.

We must acknowledge that with the current state of the art of drug treatment, many women on crack will never achieve sole responsibility for the welfare of their children. We must develop more models that take advantage of and maintain positive elements within the birth family, and also acknowledge formally and informally the roles of extended families and new types of foster families.

**Selection, training, and support of workers:**

Workers should be selected for their ability to form supportive relationships that convey compassion, respect, and empathy. They

should avoid confrontation that can reinforce women's sense of powerlessness and low self-esteem. They should receive training in comprehensive assessment, motivation enhancement, and relapse prevention.

Although the problems of helping women on crack overcome their difficulties and successfully nurture their children may at times seem insurmountable, we have countless promising options for improving our ability to respond to them. We can and will do better.

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