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IN THIS ISSUE

CASE MANAGEMENT FOR SUBSTANCE ABUSING PARENTS AND THEIR CHILDREN: A VIEW FROM EUROPE

Substance abusing families in the Netherlands and Belgium

In the European Union, it is estimated that—depending on the country—18 to 75% of all female substance abusers have at least one child, and trend figures show that this percentage continues to grow (EMCDDA, 2000). Approximately 2,000 to 3,000 children in the Netherlands are children of intravenous drug users, of whom about 70% live with their parents (Leopold & Steffan, 1997). In Belgium, it is estimated that approximately 1,000 children of substance abusing mothers are born every year (Piron, 1996). These figures probably underestimate the real extent of the problem, as many substance abusing mothers are not recognized by the registering authorities and treatment services.

Though parenthood seems to be an important life-event for most substance users (Deren, 1986), substance abuse clearly is a risk factor for the development of children due to, among others, drug use during pregnancy, adverse family history, dysfunctional family patterns, life-style and coping skills of the parents, emotional neglect and abuse, lack of parental and interaction skills,

and feelings of shame and fear among the mothers (Powis et al., 2000; Vanderplasschen et al., 2002b). However, other characteristics, such as the presence of a social network, family rituals and controlled drug use, contribute to adequate parental functioning. Substance abuse should thus be regarded as a factor that endangers, rather than handicaps, good parenting (Marcenko et al., 2000).

Nonetheless, due to the potential risks for children's development, the complex problems of substance abusing parents and their children, and the involvement of child, health care and social welfare services, a comprehensive approach to services is required. All over Europe, several specific—mainly residential—initiatives have been established, and existing services have been adapted, to deal with this target group since the 1990s (Leopold & Steffan, 1997; Hedrich, 2000). To improve the accessibility of services for substance abusing parents, various low threshold initiatives have been set up. Among these is case management, which is intended to guide substance abusers through the complex network of services. While case management has a long tradition for assisting substance abusers in the United States (Siegal, 1998), its

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practice among substance abusers in Europe is limited to a few countries (Belgium, the Netherlands, and Germany) (EMCDDA, 2001).

AIMS AND METHODS

This article reviews experiences and empirical findings from several case management projects for substance abusing mothers and their children (0-6 years) in the Netherlands and Belgium. Both countries were among the first in Europe to implement case management, and they have a similar health care and social welfare system and a comparable drug using population, mainly opiate abusers. The article focuses on issues concerning implementation of case management, as several authors (e.g. Jerrell & Ridgely, 1999; Burns et al., 2001) have identified deliberate implementation (i.e., the use of several critical program elements) as a crucial factor for effective case management. It also presents recommendations for implementation based on a survey among case management practices in metropolitan areas in the Netherlands (Bool, 2002) and the evaluation of a pilot project in Antwerp, Belgium. These findings are complemented with empirical findings from other case management studies directed at substance abusing and other mental health populations in Belgium, the Netherlands, and Germany.

Case management for substance abusing parents and their children

Case management has been described as a variety of individualized services, provided by one case manager or a team of case managers (Graham et al., 1995), to guarantee the coordination and continuity of care for persons with multiple and complex problems (Vanderplasschen et al., 2002a). Assessment, planning, linking, monitoring and advocacy are identified as its basic functions (Siegal, 1998). This intervention is further marked by the following principles: client-driven, a single point of contact within the health and social services systems, advocacy, community-based, pragmatic, anticipatory, flexible, and culturally sensitive. Based on the extent to which these functions and principles are performed, 4 different models of case management can be distinguished: the brokerage/generalist model, the strengths perspective, assertive community treatment/intensive case management, and the clinical/rehabilitation model (Siegal, 1998).

The **brokerage model** is a very brief approach in which case managers, during a few initial contacts, help clients identify their needs and access identified resources. With this model, case managers have very little contact with the clients and provide no active advocacy. Probably most case management practices can be referred to as **generalist models** and utilize all of the commonly accepted functions of case management (Siegal, 1998). While this approach has taken many different forms, it generally involves coordinated linkage to community resources. The **strengths-based model** is a specialized approach to case management and encourages substance abusers to identify their strengths and assert direct control over their search for resources. **Assertive community treatment** is intended to maximize the integration of services using a team of case managers, providing comprehensive services directly to clients rather than referring them to existing services. Intensive case management is a similar variation, using even smaller caseloads and more intensive and frequent contacts. The **clinical/rehabilitation approach** combines resource acquisition (case management) with clinical activities, including psychotherapy and teaching of specific skills, and seems most appropriate for populations that are best addressed through a therapeutic relationship with one single caregiver (e.g. substance abusing mothers).

Although no discernable benefits have been found related to the brokerage model of intervention (Bool, 2002), various positive effects have been linked to each of the other case management-models (cf. Rapp et al., 1998; Vanderplasschen et al., 2001, Wolf et al., 2002). However, the application of case management among substance abusing families is limited to a few studies. Results mainly indicate positive effects on parental functioning, but far less influence of this intervention on children's development (cf. Laken & Ager, 1996; Catalano et al., 1999; Bool, 2002).

The first application of case management for substance abusing mothers and their children in the Netherlands goes back to 1986, when a brokerage model of case management was implemented in Amsterdam for linking them to the services they needed (Bool, 2002). Since, several generalist models have been started in metropolitan areas, especially with the goal of providing basic care, linking to and coordinating treatment, and protecting children at risk. In Belgium, case management has only recently been implemented (2000) for helping substance abusing families. In a pilot-study (Bubbels & Babbels, Antwerp), a generalist model is used to minimize the risk of developmental problems among these children and to improve cooperation between childcare, social welfare and substance abuse treatment services (Claes, 2002). Case managers

coordinate all services provided, with the goal of keeping these families together if possible.

Issues concerning implementation of case management

Based on the recommendations of Wolf (1995), at least 15 advices can be formulated for the implementation of case management for substance abusing parents. These advices are illustrated with theoretical and empirical findings, and they concern both structural aspects and topics related to the content of this intervention. They also include indicators for the conceptualization of case management as suggested by Robinson and Bergman (1989).

CONCEPTUALIZE A CASE MANAGEMENT MODEL THAT ADDRESSES THE CAUSE FOR AND OBJECTIVES OF ITS IMPLEMENTATION

As case management is a specific intervention, its implementation should be based on an explicit motivation and clear objectives (Wolf et al., 2002). The purpose of using this intervention to help substance abusing families is its potential for addressing complex and interwoven problems of client-systems at all levels (Brindis & Theidon, 1997). The main objectives are providing basic care, monitoring and protecting children's development, and linking clients to the services they need. If these objectives cannot be realized, the conceptualization may need to be adapted, or case management can be questioned as a proper method for meeting the defined problem.

DEFINE THE TASKS OF THE CASE MANAGER

Case managers' tasks, competencies, and responsibilities should be clearly defined to all parties involved, so that it is clear what can be expected (Vanderplasschen et al., 2001). If case managers combine their function with another part-time job, both jobs should be clearly distinguished so they do not interfere. Besides the above-mentioned basic functions, coordination and outreach are two additional crucial functions in assisting substance abusing families. As various services often are involved in helping this target group, coordination will be necessary for providing comprehensive and effective care (Mallouh, 1996). Stigmatization by society and the social welfare system, the potential harm of substance abuse for their child, the risk of having their children removed and further social exclusion, and consequent feelings of shame and guilt, have been identified as important barriers for entering treatment among substance abusing mothers (Klee & Jackson, 1998; Whiteside-Mansell et al., 1999). Therefore, outreach activities are needed to enhance treatment access, participation and retention (Laken & Ager, 1996; Brindis & Theidon, 1997).

FORMALIZE COLLABORATION, COMMUNICATION AND DELIBERATION

Though informal contacts ("social services bartering") can facilitate collaboration and cooperation between services (Vanderplasschen et al., 2002a), formal and signed agreements between services are a prerequisite for good collaboration, deliberation and communication (Siegal, 1998). Clear arrangements concerning privacy ("informed consent") and

professional secrecy are extremely important for dealing with substance abusing families (Derluyn et al., 2000). Formal and regular case conferences also can be an important addition to intensive case management practices (Bool, 2002).

INTEGRATE CASE MANAGEMENT IN THE SYSTEM OF SERVICES

Case management should be an integral part of, and have a clear role in, the network of services for substance abusing families. Within an integrated treatment system, case management is often regarded as the connection between different services (Broekaert & Vanderplasschen, in press). The in- and exclusion criteria for case management need to be made explicit, so that clients can be referred appropriately from or to other services. However, case management is best conceptualized as a voluntary intervention (Bool, 2002).

APPOINT A COORDINATOR OR PROJECT-LEADER

A coordinator or project leader is required for facilitating the implementation process, i.e., informing other services about the project, arranging formal agreements between services and agencies, creating prior conditions for doing case management, monitoring and supervising the project, mediating disputes, data registration, and evaluation (Wolf et al., 2002). To keep in close touch with the needs of substance abusing families and case management practice, project leaders should also have a minimal caseload.

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FORMULATE FEASIBLE, OPERATIONAL AND MEASURABLE GOALS

Case management is no panacea for helping individuals or families with multiple and complex problems (Moxley, 1989). No evidence is available from randomized controlled trials about the effectiveness of this intervention (cf. Volpicelli et al., 2000; Wolf et al., 2002). Moreover, the implementation of case management varies from place to place. It is, therefore, important for every starting project to postulate realistic and operational goals at organizational and individual levels, and to monitor and evaluate these by using measurable indicators. Feasible objectives are necessary as unrealistic goals might lead to frustration among clients and staff. Additionally, goals should be easily measurable by all parties, and outcomes should be used to adapt and adjust the project or goals as needed.

FOCUS ON THE STRENGTHS OF CLIENTS AND THEIR SURROUNDINGS

Case management should start from a comprehensive assessment of strengths and weaknesses of the client system (parents and children), and resources and limitations in the clients' social network. The strength-based perspective is based on encouraging persons to identify their own strengths, assert direct control over their search for resources, and use informal helping networks; promoting the primacy of the client-case manager relationship; and providing proactive outreach to clients (Rapp, 1997). Strengths-based assessment and case management can help workers cope with resistance, denial, and

thresholds in accessing treatment among substance abusers (Rapp, 1997). Although, with one exception (McLellan et al., 1999), its applicability has been seldom tested specifically among substance abusing mothers, this intervention has been proven to enhance treatment participation, retention, and overall results among substance abusers in general (Rapp et al., 1998).

INVOLVE THE MOTHER AND HER SOCIAL NETWORK IN THE TREATMENT PLANNING

Research has identified the client-driven nature of goal setting and teaching clients how to set goals as crucial factors in enhancing participation and retention in treatment services (Brun & Rapp, 2001). Moreover, involving clients' social network (including friends, family and intimate partners) is widely recognized as another factor positively affecting treatment participation, retention, and related outcomes (Price & Simmel, 2002; Soyez & Broekaert, in press). Involving clients and their surroundings actively in the treatment planning might increase adherence to, and thus contribute to the realization of, the postulated goals (Rapp, 1997).

INVOLVE THE FATHER OR A FATHER-FIGURE

Although substance abusing mothers are often involved in unstable relationships and often have traumatic experiences related to men, the presence of a father figure can be very important for the development of children. The natural/stepfather or father figure should, therefore, be included in the case management process (Derluyn et al., 2000). Moreover, male case managers can function as role models within a predominantly female team.

DEFINE THE DURATION OF THE INTERVENTION

Discussions concerning the ideal duration of case management remain unsolved (Vanderplasschen et al., 2001). Due to the complex and chronic nature of substance abuse, one might argue that most substance abusing families probably need life-long case management. Given the limited resources and the fact that case management can—to a certain extent—be considered as a learning process, we think about case management as a time-limited intervention with clear objectives. Moreover, Dutch follow-up research concerning case management with mental health populations showed that most effects attributable to case management faded away after 18 to 24 months (Kroon et al., 1999). Regardless of the exact timeframe, termination of case management should be based on mutual consent and goal achievement, and the intervention should be stopped when it no longer appears to be needed, or when it seems to have little or no impact.

CHOOSE AN ACCESSIBLE LOCATION WITH FLEXIBLE WORKING-HOURS

Though case management is a community-based intervention and outreach is an important feature, case managers should operate from a fixed and accessible location, which is a neutral place and has a low threshold for the intended target group. Flexible and extended hours are required. The availability of case managers can be extended by using cell phones and can be complemented by collaborating with emergency shelters, nurseries and detoxification centers out of working hours. The safety and

BUILDING BRIDGES BACK HOME:
PARENTAL SUBSTANCE ABUSE AND FAMILY REUNIFICATION

Parental drug or alcohol problems are present in the majority of families involved with kinship or foster care in the United States (Besieger, Garland, Litrownik, & Landsverk, 1999; GAO, 1998; Young, Gardner, & Dennis, 1998). In fact, removal of children often compels parents into treatment (Caldwell, 1998; Carten, 1996; Gerstein et al., 1997). Yet, family reunification is a major challenge and a potential relapse trigger for parents in recovery.

Therefore, reunification preparation needs to be addressed in case planning across service systems from earliest contact with the addicted parent. Although case managers (CMs) do not need to be experts in substance abuse (SA) treatment, "they need to know enough about their clients to interact with the [alcohol and other drug] system in more depth than merely handing a client a list of phone numbers of treatment centers or assuming that clients with substance abuse problems will never be able to gain control of their lives" (Young, Gardner, & Dennis, 1998, p. 103). This article explores pressing issues for families in these situations, professionals' attitudes and knowledge, and CM strategies that support families through treatment engagement and recovery toward family reunification.

Emotional Processes and Family Dynamics in Reunification

Parents in recovery, whose children are in substitute care, face multiple issues. In addition to working toward sobriety, they must also deal with the traumatic impact of separation and loss for themselves and their children, which requires them to confront issues of personal responsibility, guilt, and shame (Akin & Gregoire, 1997; Pine, Warsh, & Maluccio, 1993). Parents may face the task of reestablishing contact with their children and then learning how to parent them, perhaps for the first time. There is little opportunity to practice parenting skills while in substance abuse treatment, as most programs (except mother/child programs) discourage or outright prohibit contact with children while in the program. When such contact does occur, preparation and "debriefing" usually is insufficient, and focuses primarily on the parent's SA issues rather than on interactions, communication, or the child's needs. Parent-child bonds can grow weaker in these circumstances, and confidence in one's parenting diminishes (Fein & Staff, 1993; Hess & Folaron, 1991; Maluccio, Warsh, & Pine, 1993; Minuchin, Colapinto, & Minuchin, 1998).

If and when reunification occurs, after the initial "honeymoon period," parents find they are ill-prepared for the roller coaster of emotions and changes in family roles and routines. They have worked so hard to be ready to parent their children, and they may be surprised, hurt, disappointed, and/or angry when their children don't trust in their progress or do not accept the changes immediately or without rebellion (Bicknell-Hentges, 1995; McIntyre, 1993; Brooks & Rice, 1997; Hohman & Butt, 2001).

For the child, there is usually a mixture of emotions and expectations. They may be excited and relieved to live with their parent(s) again, while they also fear a return to previous behavior patterns. There may be denial of past problems and a naïve expectation that life will now be perfect. Anger and sadness over past neglect or abuse, confusion regarding all the changes, and resentment over a newly sober parent's attempts to assert authority are often challenging for children who were previously parentified or inadequately supervised while the parent was abusing drugs or alcohol. They are not prepared to hand back the reigns to the newly sober parent, and power struggles are extremely common, especially with adolescents (Bicknell-Hentges, 1995; Brooks & Rice, 1997; Farmer, 1996; Pine et al., 1993).

Not surprisingly, the early stages of reunification are prime time for relapse (ASPE, 1999).

Disconnects and Misconnects Between the Child Welfare and Substance Abuse Systems

Complicating the picture are workers' attitudes toward addicted parents and the gaps and misunderstandings between the substance abuse treatment and child welfare worlds. Modern SA treatment is multidimensional (addressing biological, psychological, social, and often spiritual elements), tailored to the individual's needs (at least three levels of outpatient and four levels of residential treatment available), and accepts relapse as a normative part of the recovery process toward eventual total abstinence (ASAM, 1996; Bell & Rollnick, 1996; Gorski & Miller, 1995; Miller & Rollnick, 2002; Young et al., 1998).

The child welfare system, on the other hand, approaches SA treatment as a "one size fits all, one-shot treatment, one strike and you're out" event rather than as an ongoing process (Young et al., 1998). A positive urine test is taken as evidence of failed treatment and incapacity to parent, rather than an indicator of the need for increased treatment structure or intensity. This "all or nothing" approach is understandable in the context of the child welfare system's accountability if a child is harmed when a parent relapses after reunification. However, abstinence does not necessarily guarantee child safety, and reduced use (as opposed to abstinence) does not automatically engender child endangerment.

Certainly, much more needs to be done at the highest administrative levels to bridge the gaps between the two systems. But collaboration is absolutely essential from the very first contact with the family if reunification is to succeed. Despite the gaps mentioned above, there are things that CMs can do now to help families with substance abuse problems.

Improving Treatment Engagement and Retention

CMs often view addicted parents as unmotivated for treatment, as evidenced by low enrollment and high dropout rates. But programs that tailor outreach, treatment, and case management services to the needs of addicted women and children report dramatically higher rates of reunification success *and* prevention of additional children placed in substitute care (SAMSHSA, 1995; Stevens & Arbiter, 1995). This suggests that the issue is not *whether* reunification can succeed, but rather, *what service conditions tend to facilitate success.* The para-

graphs below outline steps you can take to boost treatment engagement, retention, and reunification success.

Get educated. CMs need education about treatment. Agencies should provide SA-specific training, especially cross-training with SA workers (ASPE, 1999; Gregoire, 1994; Young et al., 1998). The more CMs know about treatment, and the more treatment providers they know, the better job they can do connecting clients with *the right kind of services* to meet their particular needs.

Take the family's lead. Treatment engagement and retention are enhanced when the *client's perceived* most pressing issues are addressed first. CMs should ask the family what it sees as its most important needs, rather than simply referring them to parenting classes. Even if their biggest priority doesn't match yours, responsiveness to their concerns builds trust and cooperation that can lead to treatment engagement and completion (Young et al., 1998).

Provide aggressive outreach and linkage to supportive services. The three largest barriers to women seeking and completing treatment are stigma, fear of losing their children, and having no childcare available while in treatment (Young et al., 1998). Providing family support, child development, health care, and other services to children of substance abusers improves treatment outcomes and reduces frequency of relapse. But aggressive and persistent outreach also is necessary to engage and retain parents, especially mothers, in treatment (ASPE, 1999; GAO, 1998; Kumpfer, 1998).

It is not enough to hand an addicted parent a list of treatment facilities and tell them to "get clean". CMs need to develop ongoing relationships with SA treatment providers in their local area; they need to know what types of services are provided, for whom, and if there is a waiting list. Getting matched

with the most appropriate treatment from the beginning is absolutely vital—an addicted parent's resolve may not last long, and workers need to "strike while the iron is hot" (ASPE, 1999; Young et al., 1998). And with the ASFA timeline ticking from Day 1, there is no time to waste. Although this may be time-consuming at first, it will actually *save* time and be more effective in the long run.

Address confidentiality up front. Obtain written consent for information sharing between agencies *at the time of referral to SA services*; this can prevent delays and problems later on (GAO, 1998; Young et al., 1998). Be sure that the consent includes the names and addresses of *all* agencies and parties who might need to share information; they can all be listed on the same release as long as the information to be disclosed and purpose of the disclosure is the same for all parties. Specify the information that can be disclosed, rather than "all my records." The consent should expire only when it is no longer needed, e.g., "until the termination of child abuse/neglect case against me." Unless state law imposes a time limitation, the consent should be drafted with this broader time frame (Legal Action Center, 2003).

Qualified Service Organization Agreements (QSOAs) are another tool that may be available for overcoming information-sharing hurdles. They are agreements between agencies that allow information sharing without client consent (ASPE, 1999; Legal Action Center, 2003). Because they specifically prohibit the re-disclosure of information from the recipient to anyone else, QSOAs are not as legally powerful as the client's written consent. Client consent also is a better tool for trust-building with clients because the QSOA allows the release of information without the client's knowledge. Nevertheless, although their legal validity has not yet been firmly established in cases of child welfare and substance abuse treatment program

information-sharing, their use in this capacity holds promise for the future. For more information about QSOAs, contact the National Center on Substance Abuse and Child Welfare at www.ncsacw.samhsa.gov.

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Relapse Prevention and Planning

Address parents' ambivalence. Many addicted parents have serious doubts about their ability to parent even though they desperately want to do a good job (Hess & Folaron, 1991). A broad view of family reunification is helpful—although many parents will eventually be able to assume full-time care of their children, some will not. CMs should consider alternative plans (including kinship care and adoption, voluntary relinquishment, and open adoption) that allow children to have the maximum family contact conducive to their sense of continuity and security. If the only options are full-time custody or total cutoff via termination of parental rights, some parents will sooner "disappear" than fail again (Pine et al., 1993; Young et al., 1998).

Talk about relapse. Expect relapse, and do not take it as evidence of failed treatment. CMs should talk with parents about the feelings and family processes described above, and how they might contribute to relapse vulnerability as families move toward and into reunification. Parents are usually afraid to admit concerns or problems to CMs for fear that their children will be removed again. In fact, not sharing these concerns is the greater danger (Gorski & Miller, 1995). Therefore, CMs should address these issues directly with parents and use their ongoing connections with treatment providers to assure that these issues are addressed within the treatment setting as well.

Take it slow. CMs should create a gradual, planful transition with supports in place to help families reckon with the fallout of earlier relational patterns and create new ones as they move toward the maximal level of reunification indicated. Pay attention to relationships between parents, children, and substitute caregivers, and facilitate collaboration among them (ASPE, 1999; Bicknell-Hentges, 1995; Edelstein, Burge, & Waterman, 2001; Friedman, 2001; Hess & Proch, 1988; Minuchin et al., 1998; Sumner-Mayer, in preparation). Also, Medicaid and other funding sources can be used to secure supportive psychotherapy services for children and families to help them work through issues related to trauma, loss, separation, and reunification.

Continual progress monitoring. Courts can be an important resource in reunification planning. Contingency contracting between parents, CM, treatment providers, and the judge can help keep parents on track and help to manage CMs' anxiety regarding accountability for child safety. Regular (biweekly or monthly) progress reports from SA providers can help to inform this process, and differential sanctions can be used to reward or restrict parents according to compliance with requirements vis a vis SA treatment and child contact. Such contingency contracting processes can include discussions of relapse vulnerability and planning for child safety in the event of a relapse (ASPE, 1999; Young et al., 1998).

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Supporting Sustained Recovery and Reunification: Aftercare

CMs can use their knowledge of reunification, family dynamics, and relapse vulnerability discussed above to become sustaining supports to parents after their period of formal treatment ends. Aftercare plans should be developed with linkages to family support services, relapse prevention, and services for children. CMs also should be aware of, and provide linkages to, SA prevention services for children, including services specifically targeted to children of substance abusers, which may be available through local family service agencies, youth service organizations, churches, or schools. The Children of Alcoholics Foundation's website (www.coaf.org) also offers helpful information and resources for starting children's support groups. Finally, CMs can help parents to create drug-free leisure time and alternatives to the people, places, and things formerly associated with use. Therefore, safe, affordable, and sober housing is a major concern, as is employment. CMs can advocate for parents, and help them advocate for themselves, with these other systems.

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Conclusion

We are only beginning to develop effective services and policies to support families with SA problems, but the practices described above can produce immediate results. Although some addicted parents will not succeed in treatment or reunification, a great many can successfully reunify and sustain eventual abstinence with well-matched treatment and appropriate supports. CMs have incredible power to inspire, support, refer, deter, and build to assist families in this process.

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A Symposium

Spirituality:

A Powerful Force in Women's Recovery

This symposium will consider the role that spirituality plays in the recovery process for women from various ethnic and racial backgrounds, and help service providers integrate spirituality into their work with women in recovery. The following will be addressed: What do we mean by spirituality? How is spirituality distinct from religion? How is spirituality core to the healing process for women? How can we help women to address the spiritual dimensions in their lives and recovery? Experts in the connection between substance abuse and spirituality will present information and guide discussion groups to help participants explore and gain a better understanding of these issues. The forum is designed for anyone working with women affected by substance abuse.

Invited keynote speakers:

- Stephanie Covington
- China Galland
- Rosalinda Ramirez

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WOMEN'S CHOICES:
CASE MANAGEMENT FOR WOMEN LEAVING
JAILS AND PRISONS

Introduction

Behaviors associated with addiction (e.g., drug sales, theft and prostitution) bring many people, particularly those who are poor and from communities of color, into the criminal justice system. Data on prisoners show the population to have higher rates of substance abuse, HIV, and mental illness than the general population, with lower rates of skills that make for healthy, independent lives, i.e., education and job skills. Kennedy, Hammett, and Rosenberg (2001) describe the correctional/criminal justice population as "disproportionately burdened" with physical and mental health problems, and the Bureau of Justice Statistics data indicate that 31 percent of people incarcerated in state prisons report a medical problem (Maruschak & Beck, 2001). Therefore, effective health-related case management services, that address the multiple dimensions of reentry (health, employment, housing), are necessary to help facilitate the process of "prisoner reentry" to the community (Travis, Solomon & Waul, 2001).

Post-release case management is especially important for women, who tend to have the highest rates of health and mental health problems and the least of life's accoutrements. Teplin, Abram & McClelland (1996) found that 19 percent of women detainees are diagnosed with schizophrenia, bipolar disorder or major depression, compared to 9 percent of male detainees; 34 percent of women in jails and prisons are diagnosed with post traumatic stress disorder; and 75 percent of severely mentally ill women detainees have a co-occurring substance abuse problem. Women in the criminal justice system also have high rates of HIV as shown in New York State where an estimated 18 percent of the female prison population is HIV positive (NYS Department of Health, 2002).

Additionally, most incarcerated women are parents (Mumola, 2000), and imprisonment and attendant problems (e.g., addiction and HIV) have consequences for their families and communities. Two-thirds of women in prison in the United States have at least one child under the age of 18, and 71 percent of these women lived with their children prior to incarceration (Greenfeld & Snell, 1999). Nonetheless, issues related to post-release family reunification have until recently been overlooked. The social stigma attached to incarceration discourages both children and families (caretakers) from seeking help and contributes to the social isolation of the entire family, including the children (Sack, 1977; Jacobs, 1995). Therefore, services that help women plan for reuniting with children as they transition from a total (custodial) institution to the community are a particularly important part of case management and reentry services.

While case management is a term used to cover diverse approaches to service integration, common "best practice" elements include: an individualized client assessment using a strength-based approach, development of a service plan to address needs and interests identified through the assessment, service brokering (i.e., referral to services), and service plan monitoring (i.e., tracking service utilization). The unique and complex social contexts surrounding women transitioning from jail or prison also require a case management approach that is advocacy-oriented and embraces a "stages of change" methodology and an open door policy that allows clients to drop in and out of services.

Women's CHOICES: A Case Management Program for Women Leaving Jail

Women's CHOICES, a prevention case management program conducted by the Center for Community Alternatives in Syracuse, New York, is a CDC/HRSA-funded project of the "New York State Demonstration Projects for Individuals Involved in the Criminal Justice System in Correctional Settings and the Community." New York State and six other states were awarded grants to implement and evaluate the effectiveness of enhanced, innovative, continuity-of-care programs whose goals are to break the cycle of recidivism, disease and substance abuse for inmates released from prisons and jails.

There are currently about 3,100 women in New York State prisons and

200 in the Onondaga County Correctional Facility, the site of the described project. Few inmates receive treatment for the underlying problems that led to their incarceration (e.g., substance abuse, mental illness), and even fewer receive discharge plans to community treatment providers. The release of prisoners without effective supports creates a community health problem as they return home at risk for continuing substance use, contracting and spreading HIV, psychological problems, and behavioral dysfunction. Prisoners are often released without the information to find the resources they need, and many are wary of service providers. Women's CHOICES seeks to bridge these service gaps for female inmates incarcerated at Onondaga County Correctional Facility (OCCF) in upstate New York.

Since August 2000, Women's CHOICES has served 84 women: 67 percent African-American, 31 percent Caucasian, and 2 percent Latina. The average age of program participants is 37, and 70 percent have children, although about half of them do not have custody.

The intervention model relies on the use of a Prevention Case Manager (PCM) who had over 14 years of experience providing case management and supportive services to homeless and dual diagnosis clients prior to assuming her current role as PCM of Women's CHOICES. She serves between 24 and 40 clients per year. At any given time, she works with 4-5 women in jail and 12-15 women in the community post-release.

The PCM attempts to bridge the service gaps for incarcerated women by providing pre-release and post-release services. The first involves the introduction of services to women while they are still incarcerated. The PCM engages the inmate two or more months before her release date. Through weekly jail-based case management meetings, the PCM completes a thorough needs assessment that results in a client-centered discharge plan. In addition to these weekly meetings, the inmate participates in twice weekly Self-Development Group meetings. Co-facilitated by the PCM and the Women's CHOICES Project Director, these group sessions cover an eight-week curriculum designed to help the inmate develop future goals, gain problem solving and self-management skills, and acquire critical information about substance use, sexual health, interpersonal relationships, and employment that will be utilized to continue behavior change following release. Additionally, if Child Protective Services is involved, the PCM works closely with the child welfare worker to help prepare the family for reunification. She also serves as an advocate for the mother and works with service providers with whom the child is involved (e.g., day care, pediatrician) to help the mother fulfill her parental obligations.

The PCM continues working with the client for a year following release in order to maintain a strong relationship with and reassess the needs of the client, refine service plans, and provide ongoing support. The PCM functions as a safety net ensuring that clients do not fall through the cracks and that they will have an advocate to re-engage them in services should they lose connections to referral agencies. Specifically, during the first month post-release, inmates are scheduled to meet with the PCM twice weekly in order to facilitate a smooth transition back into the community. Once they are stable, the PCM meets with each client twice a month to assess their progress.

During this period, the PCM makes referrals based on emerging treatment and service needs, and has routine face-to-face and telephone contact with program participants and other service providers assisting them. Additionally, clients attend a twice monthly community-based support group that is co-facilitated by the PCM and the Project Director. Group members support and advise each other as they struggle to make changes in their behaviors and relationships. Providing these services within a "stages of change" approach has resulted in the retention of 66 percent of the women in the post-release case management services in the last year.

The Challenges of Effective Prevention Case Management

Women's CHOICES clients are not mandated to participate in services. Nearly all are released without Probation, Parole or [Drug] Treatment Court requirements. Consequently, one of the PCM's greatest challenges is to engage clients who are reluctant to engage in services, particularly substance abuse treatment. Most of the women in jail have participated in drug treatment prior to their incarceration and have reservations about reengaging in services that were not successful in the past. Moreover, they are not interested in entering residential treatment after spending a year in confinement. Many of the clients also have histories of abuse and trauma, and report anxiety, depression and interpersonal conflicts that compromise their adjustment in the community. Few have recognized the need for counseling, and although many would benefit from a dual-diagnosis

program, there are almost no services that treat co-occurring disorders, particularly within a gender-responsive context.

The Women's CHOICES clients are also challenging to assist because of their crisis-driven life style fostered in part by extreme poverty. Their lives are characterized by instability and new, emerging needs and crises that disrupt the PCM's efforts to engage the clients in long-term planning. Further, ongoing family problems may contribute to parenting challenges. Some clients have temporarily or permanently lost custody of their children. Those who retain custody may have difficulty effectively parenting their children due to their own histories of childhood neglect and abuse, absence of effective parental role models, and lack of opportunity to develop parenting skills. Additionally, their children have experienced the loss and trauma associated with their mothers' substance abuse, psychopathology, and incarceration; and some experience attention problems and developmental impairments.

When clients are in constant crisis, it is hard to focus on their substance abuse or their risk for contracting HIV. Their basic needs must be met first. For many of these clients, finishing a treatment program or staying connected with a case manager is a measure of success.

Philosophical Approach

Abstinence only models set unrealistic expectations for clients who struggle with recovery among many other daily challenges. Thus, Women's CHOICES employs a client-centered, harm reduction focus that utilizes stage-based behavioral counseling based on the Transtheoretical Model of Behavior Change Theory in order to help clients

reduce the risk and harm associated with their substance use and sexual behavior (Prochaska, DiClemente, & Norcross, 1992). Stage-based behavioral counseling requires the PCM to assess the client's motivation to change a target behavior (e.g., substance abuse, unprotected sexual activity with multiple partners), and to deliver an intervention most likely to be effective given the client's motivational level. For example, clients who see no need to change their substance use are more likely to become motivated to consider behavior change if they are provided with information about the problem drinking and its effects on their life or examples from other substance users' lives.

The Role of Case Management Supervision

Case management with women inmates struggling with the multiple burdens of substance abuse, psychopathology, intergenerational family problems, the legal consequences of their dysfunctional behavior, and socio-economic challenges stemming from discrimination and community-wide poverty, is challenging. Helping professionals enter the field with a conviction to make a "big" difference in the lives of their clients. When their expectations are not realized, PCMs can become frustrated, overwhelmed and demoralized. When efforts to promote healthier choices and sound decision making stall, PCMs may blame themselves or the client, their family or others involved in the case; avoid contact with the client; or leave the agency burned out and cynical (Kagan & Schlosberg, 1989). Clinical supervision thus becomes a key factor in helping PCMs manage their feelings and

expectations so that they can remain engaged with, but not overwhelmed by, the client.

Clinical supervision, distinct from administrative supervision, focuses on the interpersonal behavior patterns of the client and the manner in which those dynamics are revealed in the relationship with the case manager (Kagan & Schlosberg, 1989). Such supervision also reviews the ongoing needs assessment of the client and aids in treatment plan development. Clinical supervision must be regularly scheduled and not driven by the clients' crises. Scheduled supervision helps the PCM prioritize and plan the case issues on which to seek consultation. The supervisor assists the PCM to maintain a broad view of the competing needs and problems with which the client is struggling so that important issues for intervention aren't neglected when clients move through various crises. Regular supervision provides PCMs with support in using their reactions to better understand clients' behavioral patterns and maintaining realistic expectations. In doing so, the supervisor must avoid becoming overly identified with the PCM or they, too, will be caught up in the PCM's frustration and disappointment with the client and be less effective as a supervisor.

Conclusion

With experience, training and ongoing clinical supervision in a harm reduction, stage-based and client-centered approach, case managers can learn not to impose their own opinions or goals on their clients. Instead, they are able to ask their clients how they can be of help to them. Based on the experience of Women's CHOICES, this approach

appears to be effective at helping women prisoners address the multiple, challenging issues they face as they attempt to reenter to the community.

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CALL FOR ARTICLES

The National AIA Resource Center is soliciting articles for the fall 2003 and winter 2004 issues of *The Source*. This bi-annual newsletter is distributed to over 2,000 administrators, policy makers, and direct line staff throughout the country, and is available on-line.

The **fall 2003 issue** will focus on **parenting education and support for parents affected by alcohol and other drugs**. Specifically, we are interested in any innovative strategies for helping parents develop adequate parenting skills and establish healthy family roles as they become clean and sober. We welcome models that are used in various settings (e.g., residential treatment, center- and home-based), during all stages of the recovery process, and with various care-givers (e.g., birth parents, kin providers, foster and adoptive parents). Articles should provide practical information supported (when possible and appropriate) by research.

The **spring 2004 issue** will focus on **safe and stable housing for families affected by substance abuse and/or HIV.** Specifically, we are looking for articles that describe effective and/or innovative strategies for helping families affected by substance abuse and/or HIV obtain safe and stable housing with necessary support services (when appropriate), and for helping these families prepare for independent living (e.g., credit clearance, tenant education). Articles should provide practical information, as well as necessary policy changes and available funding sources.

To be considered for publication, please send/fax/email a brief (150-200 words) abstract of your proposed article to the AIA Resource Center at the address below. **Abstracts for the fall issue are due Friday, June 13, 2003. Abstracts for the spring issue are due Friday, September 26, 2003**.

SEND ABSTRACTS AND DIRECT QUESTIONS TO:

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THE BODEGA MODEL:
A FAMILY FOCUSED APPROACH FOR RETURNING PRISONERS

Introduction

The close relationship between substance abuse and the criminal justice system is an undeniable reality that post incarceration programs, both government and community based, must contend with. An estimated 80% of all prisoners are incarcerated for drug-related offenses (CASA, 1998). When these individuals are released from prison, the family, community, and reentering prisoner face numerous challenges. Systemic failures of reentry supervision often result in repeated criminal activity, rearrests, and most importantly, destabilized families and communities. It has long been thought that community based and criminal justice supervision agencies need a new tactic for serving the paroled population of individuals suffering from alcohol and other drug abuse. Family Justice, a private agency in New York City's Lower East Side, looks to accomplish this by tapping a natural resource, the family, and by working in partnership with government and community based organizations. La Bodega de la Familia, Family Justice's direct service arm, began as a demonstration project of the Vera Institute of Justice to test whether engaging and supporting the families of substance abusers under justice supervision could: (1) enhance drug treatment outcomes, (2) reduce

the use of jail to punish relapse, and (3) reduce harm to families.

A close look at the composite of the people affected by a person's reentry reveals that most often, the biggest stakeholder is the family.[1] They are often both direct and indirect past victims of the reentering offender as well as the most familiar and unconditional support. Therefore, focusing supervision efforts around the resource of the family is a logical and potentially powerful method of community supervision. This article describes the model developed by La Bodega de la Familia, which is based on the belief that the families that have been destabilized by drugs and crime are very often the most influential, empowering, coercive, and stabilizing force to keep a prisoner returning to the community drug and crime free.

The Bodega Model

Family Justice uses a unique type of family case management called the Bodega Model, originally conceived of and fine tuned at La Bodega. The model has been organically crafted and structured over the years since La Bodega was founded in 1996. But it was the planning process that occurred over the course of one year before we even opened our doors that proved most influential. This process formed the foundation of the model and fostered key relationships with local law enforcement, public housing and other

government officials, local neighborhood organizations (both formal and informal), and residents of the community. It was during this planning process that Bodega's niche emerged to complement existing resources and a program design that would build upon the inherent strengths of the community.

The Bodega Model borrowed heavily from four disciplines: family systems practices, strengths-based models, case management principles, and the rich literature on partnering and collaboration. It is the confluence of these disciplines that form the framework for our practice. The first component—family systems work—draws upon family members' mutual loyalties, inherent strengths, support, and availability. The second component—strengths-based models—incorporates each family member's inherent competencies, resiliencies, and unique culture, as well as the strengths of the government agents and community. The third—case management—recognizes the series of systematic interventions required to "manage" a family. Although qualifications vary among La Bodega case managers (e.g., some have MSWs and others have only undergraduate degrees), they all have formal and/or informal training in case management, and each carries a caseload of 25-30. The last discipline—collaboration—exploits the reality that families are intertwined with multiple systems and the need to forge realistic and useful bonds with those organizations. To

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[1] "Family" is broadly defined to include the network of people who are significant in the parolee's life. These people, if approached properly, are generally willing to provide support and assistance.

this end, strong partnerships with parole, probation, police, and a host of community-based, social services and health organizations are fundamental to the program design. In fact, four full-time parole officers and one supervisor are assigned to work exclusively with parolees through La Bodega.

The Model in Practice

The Bodega model consists of three phases (see insert) over the course of approximately one year.

PHASE ONE

Phase One involves engaging the family in the case management process, often beginning with a home visit with a parole officer prior to the release of a family's loved one from prison. At this time, a Bodega case manager will inform the family of the available services and offer support in preparing for the return of a loved one. A look at family picture albums or a conversation about better times is often a good beginning to forming a relationship. Expectations about parole are discussed, including fears, anxieties, and excitement about a loved one's return.

Once the family member is released from prison, a Bodega family case manager starts a process to identify family strengths and gain a better understanding of the community and family relationships that serve as a resource. Bodega uses two specific tools: the ecomap and the genogram. The ecomap helps the case manager learn about family connections to both government and informal systems. A single family, for instance, may be involved in multiple formal

government systems (e.g., child welfare, public housing, probation, parole, SSI, and drug treatment), as well as informal systems (e.g., house of worship, community center). Knowing these relationships is critical in order to coordinate services and prevent family members or government agencies from acting at cross-purposes. Ecomaps are a valuable tool that vividly display conflicts or sources of support between services in which families are entrenched; they also are a visual reminder of the need for coordination.

Genograms are an equally valuable tool to help families look at their history of drug use, criminal justice involvement, and mental illness as a

way of understanding the potential impact on the next generation. Family Case Managers use this "family map" to provide a picture through which a family can better understand and know its strengths, weaknesses, and general characteristics.

With use of these tools, the overall goals of *phase one* are to: (1) provide a conceptual framework from which a family can redefine itself in terms of the people and organizations around it; (2) highlight the likely efforts necessary to make the challenges a family faces less daunting and more doable; and (3) inform the overall supervision process so that a parole officer recognizes the "family" as a formidable and useful

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A Flow Chart for The Bodega Model—Family Case Managment (FCM)

	ACTIVITIES	GOALS
Initial Contact →	• Assess for crisis • Determine eligibility for FCM • Release of information signed	• Refer out, • Refer to FCM, or • Refer to other La Bodega services
↓		
Phase One Engagement and Assessment →	• Join (develop working relationship among FCM team) • Develop *Genograms a*nd *ecomap* • Look at family photos • Assess family needs for services • Explain The Bodega Model and how the government partnership works	• Identify strengths and areas of conflict • Identify community resources • Establish working partnership among FCM team members
↓		
Phase Two Family Action Plan →	• Create and implement *family action plan* • Set behavior goals • Mobilize family members • Support family problem solving • Refer to and engage collateral government and community based agencies • Conduct ongoing home visits	* Prevent relapse & new crimes • Reduce level of supervision of parolees and probationers • Improve treatment outcomes • Strengthen relationships of family members • Meet family needs for referral services
↓		
Phase Three The Bridge Project (under development) →	• Transition from FCM • Mobilize peer support • Teach leadership skills • Maintain contact through group and community activities	• Sustain benefits achieved through FCM * Develop leadership abilities and community involvement • Reduce dependence on La Bodega • Sustain compliance with supervision and treatment mandates • Enhance overall family well being

•*Members of the FCM team include the identified substance user (ISU), other family members (OFMs), the parole or probation officer, and a La Bodega family case manager*

partner. These tools provide a concrete means to engage the family and form a meaningful partnership with Bodega and parole staff. This entire process generally takes two-to-three months.

PHASE TWO

The second phase of the Bodega Model includes a critical process during which the family case management (FCM) team develops and follows a detailed *family action plan.* The family action plan serves as a guide through the FCM process; it sets short and long-term goals and provides a flexible mechanism to readjust the plan as needed. As the parole officer and family case manager work with the parolee and his or her family, needs and considerations of all parties are factored into setting goals. For example, does the parent have demands from caring for a small child? Will methadone maintenance conflict with medication and visits to the clinic? How can employment demands be worked into an already busy treatment schedule? How will guardianship of a child be negotiated over the course of reentry? In short, the issues unveiled through the ecomap and the demands of parole supervision, coupled with family demands, are mapped and goals set accordingly. Once the family action plan is developed, there are three, six and nine month reviews when readjustments are made as indicated.

Throughout the family action plan process, it is critical to provide a safe space for the whole family. Recognizing that relapse is a common occurrence for those struggling with addiction, La Bodega designed interventions that address public and private safety. For instance, La Bodega has 24-hour on-call support services for families and their loved ones in the event of a drug related emergency. Not only is this critical as a means to maintain public safety, but

this service insures that there is a place to turn to for everyone involved. Parole and formal systems are only available during "normal" working hours; and families and loved ones are more likely to turn to a neutral organization rather than law enforcement when a loved one relapses or they are worried. In New York State, the director of Parole sees this component as a true public safety initiative: Who is likely to know first when a loved one is at risk for criminal activity, a parole officer or girlfriend?

Further, when relapse occurs, a team meeting is usually held to decide the best course of action. In lieu of a parole officer exercising supreme authority, family members and the Bodega family case manager partner with the parolee and the parole officer to identify the best intervention, preferably a community-based option. This methodology empowers all players and fortifies that the parolee and his or her family are truly the experts in their own lives.

PHASE THREE

Family Justice is now developing a third phase for the Bodega Model called the Bridge Project. As its name suggests, the Bridge Project is designed to create a bridge from an intensive family case management service to a less intensive service. The Bridge Project will reach out to all family members involved in the FCM process, and will aim to sustain the benefits of family case management with a new set of activities. It will build on the successes of the family action plan by fortifying the transition from community supervision to life in the community without supervision and without the constant support of La Bodega staff.

There are three goals to this third phase: 1) to sustain and build upon the gains of community-based drug

treatment, 2) to prevent rearrest, reincarceration, and other criminal justice involvement, and 3) to enhance family well-being (e.g., improve physical and mental health, housing, and employment opportunities). The Bridge Project will reassure participants that the FCM team continues to be concerned about their success and well-being, and will provide family members with a range of services and referrals to needed community services. This key phase will allow participants to remain connected to La Bodega for approximately two-to-three months after completing its intensive FCM program, and to encourage local leadership within the community.

Outcomes

Since 1996, La Bodega has served more than 800 families, with capacity to serve 125 families at a time. About 90% of the parolees served are male, and most are Latino. About 30% of the families served are involved with the child welfare system, although staff are working collaboratively with family courts to expand that number.

In April of 2002, Vera Institute of Justice released an evaluation of La Bodega entitled *Families as a Resource in Recovery from Drug Abuse: An Evaluation of La Bodega de La Familia.* The evaluation found that family case management was successful at Family Justice, and that "La Bodega led to real improvements in the lives of drug users and their family members" (Pope, 2002, 54). The study also found that "illegal drug use among Bodega participants declined significantly, from 80 percent to 42 percent. The drop in cocaine use was dramatic—from 42 percent in the month before they entered the study to 10 percent six months later" (Pope, 2002, 54). The evaluation also noted that "with their reduced reliance on drugs, Bodega participants also were less likely to be arrested and convicted of a

UPCOMING AIA TELECONFERENCES

All teleconferences are scheduled at 2:00-3:30 p.m. Eastern Time

Unique Challenges and Transitional Issues for Relative Care Providers

Thursday, June 12, 2003

Joseph Crumbley, DSW Psychotherapist, Individual and Family Private Practice, Philadelphia, PA

This presentation will focus on the unique challenges relative caregivers face. Dr. Crumbley will focus on the changes in family dynamics in the kinship family. He will also share strategies and approaches for supporting the relative caregiver with transitional and emotional issues.

The Mental Health Needs of HIV-Infected Children and Adolescents

Tuesday, July 15, 2003

Claude Mellins, PhD Assistant Professor, Department of Psychiatry, Columbia University; Director, Family Studies program, HIV Center for Clinical and Behavioral Studies, New York State Psychiatric Institute; Co-director, Special Needs Clinic, New York Presbyterian Hospital

Increasing numbers of HIV-infected children are surviving into adolescence and must cope with a stigmatizing, potentially fatal, chronic illness. Many must confront the impact of the disease on mental health and normative developmental processes such as puberty, growth, peer relationships, and sexuality. This teleconference will address the epidemiology of perinatal HIV infection in the US and world; the etiology of emotional and behavioral problems; emotional and behavioral sequella; and mental health treatment.

Best Practices for Integrated Treatment and Program Development for Women who have Dual/Multiple Disorders: Mental Illness, Drug Addiction and Alcoholism

Friday, August 15, 2003

Kathleen Sciacca, MA Founding Director, Sciacca Comprehensive Service Development, New York, NY

This presentation will include best practices for integrated treatment and program development within existing or new programs, differentiating various profiles of dual/multiple disorders, and physiological aspects. Several program elements will be covered, such as screening, engagement, readiness measures, three phases of group process, group content, outcome measures, and data collection.

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The registration fee for these 90-minute, interactive telephone seminars is $25 for each session. To register, and receive the toll-free number and information packet, please complete this form and fax it to **510-643-7019**, then mail it along with your check made payable to the *U.C. Regents* to: University of California, Berkeley AIA Resource Center, Family Welfare Research Group, 1950 Addison Street, Suite 104 # 7402, Berkeley, CA 94720-7402

Please check the teleconference(s) you would like to attend:

❍ **JUNE 12, 2003**   ❍ **JULY 15, 2003**   ❍ **AUGUST 15, 2003**

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Phone: _____   Fax: _____

E-mail: _____

For more information on any of these teleconferences, please contact Margot Broaddus at AIA Resource Center (510) 643-7018 margotb@uclink.berkeley.edu

THE POWER OF PARALLEL PROCESS IN INTERVENTIONS WITH FAMILIES AFFECTED BY SUBSTANCE ABUSE

Intervention with families affected by substance abuse is challenged by the complex needs and demands on the worker orchestrating the intervention. The roles for the worker are diverse and, at times, intense as the needs of each family member are balanced in the context of an addiction. The AIA programs, as well as others in the field, have learned through personal journeys and feedback from clients, the significance of a supportive relationship to a recovering person and her family. This article will explore the parallels that exist between that therapeutic relationship and the subsequent relationships that are developed as part of the intervention. It is our belief that unless these parallel relationships are nurtured, within the context of a supportive working environment, clients will be shortchanged.

It's all about the relationship

The worker's role in a family may include a combination of direct therapeutic interventions, such as influencing the interaction between parent and child, and less direct intervention through case management activities. Whether helping a mother read her infant's cues during a home visit or coordinating several agencies attempting to intervene with the same family, the significance of the parallels in the process should be underscored. The mantra of AIA program personnel has been that *it is all about the relationship*. It is the vehicle through which the

work gets done with families directly, with staff in supervision, and with agencies within the community. C.M. Heinickie and colleagues at UCLA explored the significance of a supportive relationship for pregnant women. They found that, at the end of the first year of intervention, mothers who had the experience of a supportive weekly home visitor perceived their personal relationships with others as more emotionally satisfying and supportive (Heinickie, 1999).

Others working with mothers and their infants have emphasized the need for reflective supervision. The Zero to Three Center for Program Excellence, specialists in program delivery to mothers and infants, has defined reflective supervision as inclusive of not only the opportunity to reflect on the work with families, but as providing an opportunity for teamwork through consistent supervisory sessions (Parlakian, 2001). Trust, open communication, power sharing, empathy, and support are characteristics that universally describe these therapeutic relationships that clearly have positive ramifications for families.

TRUST AND COMMUNICATION

Trust is a basic element in all relationships. Family members clearly come to trust the worker on whom they can depend. The worker who shows up for appointments, follows through, and is honest about her agenda and expectations will gain trust. Workers, too, judge these qualities in a supervisory relationship just as colleagues in the

field make judgments about each other based on these same dynamics. Positive working relationships between community providers, whether for a voluntary service or a mandated intervention, enable the management of the case to remain focused on the needs of the family and responsive to the goals of the intervention. While not intentional, difficult relationships among service providers, as demonstrated through power struggles, lack of trust, and a narrowed focus can put families in the center of a conflict. This conflict will ultimately inflict the most damage on the family. Therefore workers, supervisors, and agencies need to attend to these interconnecting relationships to ensure case decisions and plans are not influenced by the unresolved differences between them. Consistent, open and honest communication is the first step in that process.

ADDRESSING POWER IMBALANCES

The relationship between worker and family, like the relationship between supervisor and worker, is naturally one of unequal power. This inequality is best addressed head on, with specific efforts made to share power. Strengths-based work helps families identify and access their power and use it to address their identified challenges. It is not authoritarian, hierarchical or punitive. Even when programs are not entirely voluntary, intervention should offer families options, resources and

consultation. So, too, should good supervision. As workers may have to spend a great deal of time convincing families that they are truly interested in their goals and needs, supervisors must communicate their confidence in workers' abilities and judgments. Processes are needed to solicit worker input into program vision and mission development, policies and procedures, and funding priorities. Providing access to decision making within the agency can be an important tool in empowering staff and promoting their partnership with families.

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Flexibility and Consistency

Workers are encouraged to reschedule missed appointments, demonstrate consistency, and remain flexible in order to make the most of the teachable moments and times when a family member feels safe enough and able to be reflective of their life story. These same elements need to exist in the supervisory relationship. Supervisors need to be accessible and available for consultation, necessitating a small number of workers assigned to a supervisor, just as small caseloads are desirable for workers. Yet**,** there are also concrete needs and goals to be accomplished. Workers are interacting with families within a context. Families are interfacing with numerous other agencies, and possibly a court system, that have outlined expectations as a result of their substance abuse. In the same vein, supervisors have a context; grant proposals have time frames and outcome expectations. How each party copes with dueling demands is at the essence of the intervention. Supervision provides an arena to practice, model,

and develop skills that aim to balance these dueling demands.

Supervisors also must communicate the vision of the program and the boundaries of the intervention clearly to workers. Clinical supervision is not therapy, and the obligation to assess productivity, oversee documentation, and otherwise assure quality always exists. Supervision that simply attends to administrative tasks, though, short-

> **PROVIDING ACCESS TO DECISION MAKING WITHIN THE AGENCY CAN BE AN IMPORTANT TOOL IN EMPOWERING STAFF AND PROMOTING THEIR PARTNERSHIP WITH FAMILIES.**

changes the potential of the relationship. Similarly, workers can empathize with families, provide supportive counseling, and help access resources. However, there is great value in communicating roles, expectations, and boundaries and holding one another accountable for accomplishment of certain tasks. Supervisors can demonstrate the accountability and consistency they ask of workers by making a commitment to consultation time even with competing priorities, by securing agreed upon resources for families in a timely manner, and by re-visiting issues in supervision within a consistent framework but with a willingness to consider new information. As the supervisor behaves with the worker, so will the worker be encouraged to act.

~

Autonomy and Guidance

The supervisor knows that she is not in families' homes building the intimate connections that workers are. Workers need autonomy to make field-based decisions and to try out solutions in partnership with families. This autonomy needs to be as broad as possible, based on the worker's experience, comfort level and past performance. Similarly, the worker communicates confidence in families' abilities to address their needs and to try out their solutions. Problem solving and the role of trouble shooter can be modeled in supervision. The supervisor can use her distance from the family as a vantage point from which she may see other alternatives and other motivation for behaviors. This is a helpful role the worker can also play with families.

~

Opportunity to Process Emotions

Supervisors need to acknowledge that doing this intensive, home-based work is hard. Hopefully, they know first-hand, from either practice or observation, the great rewards and extreme frustration that result from this kind of work. Workers need to be given the appropriate time and space to process their emotions without judgment. Emotions will be on a wide continuum and may sometimes be outside of traditionally acceptable expressions (i.e. "How could she use *now*?"; "She makes me so mad I want to scream!"; "I'm so proud of her I feel like her mom"). If workers are given permission to express those feelings—obviously, in a confidential environment—they will often work through them and be able to effectively continue the work. Families

often need to express painful and powerful emotions, too. They may be angry with the worker, the agency, or the world. Cognizant of the ability to effectively process their own intense emotions when given the opportunity in supervision, workers will be more able to offer that same opportunity to families and others in the field to process strong emotions without over-reacting.

Teamwork

Families will benefit from viewing themselves as part of a team, a team consisting not only of the worker but also of other service providers and their own network of family and friends. Teamwork also is important to the supervisor-worker relationship, a team comprised of the worker, supervisor, co-workers and other community advocates. Commitment to the importance of this team can be evidenced by scheduling regular staff meetings, periodic retreats, and other opportunities for peers to process the work with one another. Supervisors can encourage workers to expand their consultation network as workers encourage families not to become dependent on the worker, but to use the relationship with the worker to build relationships with other people.

As each family is part of its community, so is each agency a part of the community resource network. No family is self-sufficient, able to meet all its needs alone. Neither is any single agency able to address all the needs of multiply challenged families. To provide coordinated and comprehensive services, a multi-agency network is required to address identified needs. A "go it alone" strategy on an agency's part will undermine the building of the network and is incongruent with the

interconnectedness the recovering community advances. However, building an effective consortium is difficult. Again, roles must be defined and power must be shared. As educators, substance abuse providers, child protection personnel, health care providers and others try to work together with families, there will be disagreement. Philosophies will clash and strategies will conflict. The agencies must be able to deal with conflict, identify common ground and build as great a consensus as possible. In this way, not only is service provision enhanced, but inter-dependence and cooperation are modeled for staff and families.

Conclusion

Families, staff and even agencies can become immobilized by the many challenges they face. Families can be overwhelmed by their specific situations; staff can grow discouraged by the lack of resources; non-profit agencies are sometimes so concerned about having their activities labeled as lobbying that basic education of elected officials is shunned. To combat helplessness, it's important to recognize that one does not have to have arrived in order to bring someone else along. As a part of the empowered partner model, families, workers, and agencies can be encouraged to explore avenues to promote social change. This public advocacy can take the form of talking to friends and neighbors, signing a petition, testifying before a legislative body, or founding an advocacy organization and everything in between. The parallel process, then, is evidenced across staff, agency, and community spheres.

Maintaining a strength-based intervention that is inclusive of families' feedback and goals is the vision

shared by many AIA programs. This inclusive vision does not just happen. It develops and comes together when families, workers, administrators, and community members are supported in their roles and appreciated for their unique perspective**.** Families and workers in the field have demonstrated that interventions based solely on providing services, or accessing resources, or education cannot meet the needs of multiply challenged families. A supportive relationship between worker and family is also required to utilize families' own strengths and resources. To that end, it is important to recognize the effect of the simultaneous and parallel processes at work. An agency's relationship to its community and its own programs and supervisors' relationships with workers should model the values of trust, open communication, power sharing, empathy and support which build the foundation for effective partnership.

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JUGGLING THE MULTIPLE FACETS OF CASE MANAGEMENT WITH RELATIVE CAREGIVER FAMILIES

The number of children living with relative caregivers is increasing. According to the U.S. Census Bureau (2000), 6.3 percent of U.S. children under the age of 18 (4.5 million children) live in grandparent-headed households. The need for comprehensive programs that can address the needs of this growing population is evident. In response to this need, the Abandoned Infants Assistance Program began funding kinship caregiver programs in 1997. The Grandparents and Relatives Outreach Program (GRO) in Albuquerque, New Mexico, was among the first group of project recipients under this funding stream. GRO serves children five years of age or younger who may be at risk because of prenatal substance exposure, abuse and neglect, or other environmental conditions. Although the project initially expected an older population among its relative caregiver participants, the current enrollment includes a group that ranges in age between 35 and 77.

From its beginning, GRO incorporated a multidisciplinary model in working with grandparent and relative caregiver families, which collaborates and relies upon the services of other disciplines to provide comprehensive intervention. All members of the multidisciplinary team work together by meeting, discussing viewpoints, and making recommendations to address the needs of the entire family. In this way, GRO's holistic family approach model attempts to address the unique living situations and the challenging needs of relative caregiver families by merging the element of service coordination with the more expansive elements of case management. In addition to case management, GRO also offers the following services:

- ✴ Home visitation
- ✴ Developmental monitoring, assessment, and follow-up services
- ✴ Child social-emotional consultation
- ✴ Legal services from the University of New Mexico, Clinical Law Program
- ✴ Primary pediatric health care at weekly clinic
- ✴ Access to primary health care for relative caregivers
- ✴ Individual and family counseling services
- ✴ Relative caregiver support groups, led by a Family Psychologist
- ✴ Developmental play groups, facilitated by a Developmental Consultant

Common challenges and strategies

Who is the client? An immediate challenge in working with relative caregivers arises when the case manager must determine who the client is. The GRO program initially identifies a child under five years of age as the target client, but the focus changes as the needs of the family change. For example, a grandchild may be in need of early intervention services, but the grandmother may also be in need of medical, legal, or financial support to maintain the family unit. It can become even more difficult when the needs of the child's siblings take precedence. Then, when the situation appears difficult enough, the case manager may be faced with dealing with the biological parent who may have substance abuse issues or a desire to reunify with the children, which may affect the established grandparent-child attachment. The following example demonstrates how a case manager develops priorities based, foremost, on the needs of the child.

RAUL: CASE EXAMPLE

Raul, 10 months old, is in the care of his maternal great aunt, Margie. Raul has four older siblings, from the same birth mother, who live next door with their maternal grandmother, Ruth, all of whom are also in the GRO program. From observations made by the case manager, developmental staff, and the pediatrician, Raul appears delayed in the area of gross motor skills and speech and language. He can't sit steadily, continues to babble, and has not begun to crawl yet. Referring Raul for early intervention services seemed to be a logical first step. However, while on a home visit, his birth mother requested a private meeting with the case manager to discuss concerns she had about Raul. She and her mother, Ruth, then met with the case manager, reporting that she had observed illegal drug use in Margie's home while visiting when Raul was present. Although the case manager had engaged with Raul's caregiver, this report suggested a possibility that his well-being was compromised. His safety became a priority for the GRO team, leading to a Child Protective Services (CPS) referral. Although the case is still pending, the relationships with the family remain stable. Even the birth mother continues to maintain contact with the case manager.

In order to address all of these complex issues, the case manager had to prioritize needs. What was most important for the safety and well being of the child? What had the family identified as most important? Clearly, the needs of the whole family must be kept in mind in order to provide the best possible

outcome and maintain a balanced focus on the family unit. Nevertheless, the needs and well-being of the child are always at the forefront of care planning.

In this case, the case manager had several objectives as her focus: the relationship with the relative caregiver, Margie, who was participating in the program; the needs and concerns of the biological mother; the relationship with the extended family (maternal grandmother); and Raul's safety and developmental needs. Because the case manager had to maintain a working relationship with all parties, while addressing the needs of Raul, she asked CPS to keep the referral confidential. This would ensure that the trust would be maintained in each of the working relationships, while at the same time addressing the concerns of the mother and grandmother. Most importantly, the case manager had to advocate for Raul's safety.

Community resources to meet multiple needs. The most common needs and concerns that most relative caregivers have identified are financial hardship, childcare, respite, and medical care for themselves. Locating appropriate resources in the community can be another challenge in working with this population. For example, a majority of the grandparents or relatives who participate in GRO are between 35 and 55 years of age. Although many resources are available to seniors, 62 and older, there are limited resources available to the younger group. Relative caregivers may be financially stable when caring for their own families, but their financial situation may become strained when children become members of their households. Some relative caregivers have been forced to accept the state's foster care option in order to meet the financial needs of the family. Although all relative caregivers are eligible to receive child-only payments to help pay for the child's care under the Temporary Assistance for Needy Families (TANF),

at times this is not enough to support the growing needs of the family. Further, childcare and respite resources are extremely limited in the Albuquerque community. Relative caregivers benefit from having an advocate (e.g., case manager) to locate these resources and be the voice for stating their needs.

Second-time-around parenting. Another challenge in working with relative caregivers is educating them on healthy parenting practices. Older adults and grandparents who have parented before have a difficult time learning new or different parenting skills. Some relative caregivers take offense at being asked to learn current parenting practice, or they may assume that they are being told that their style of parenting was wrong. To encourage their participation, it is important that a case manager address the need for parenting skills from the focus of the child. How could the child benefit from a different style of parenting? What strategies could the caregiver use to help the child develop in the ways that seem most appropriate? Helping the caregiver see what the child's individual needs are may help lessen the focus on their own qualities as a parent. As the relative caregivers build a trusting relationship with the case manager, they may be more open to learn new parenting skills or to share parenting skills they feel they practice exceptionally well. Most relative caregivers are willing to do whatever is necessary for the well-being of the children.

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Effective practice in helping relative caregivers identify and prioritize needs and develop goals

The family initiates the goals. In order for case managers to be effective with families, they must meet the client where they are. If case managers work

with kinship families strictly from their own perspectives or assessments of family needs, they will most likely encounter resistance and have difficulty building trusting relationships. All clients, but especially relative caregivers, need to feel that they are being heard and that case managers will work with them, based upon what they can handle or program components in which they want to participate. Case managers must also be sensitive and responsive to the families' situations and work with them at their own pace. Some relative caregivers may have scheduling conflicts, miss appointments, and forget what they were supposed to do because they are so overwhelmed. Therefore, case managers may have to step back and accept the reality that it may take longer for the family to reach identified goals.

When assessment tools help. The use of an assessment tool is helpful in determining the needs of the family and the appropriate level of services. It also helps in prioritizing and developing goals with the family. The GRO Program uses an Environmental Risk Assessment tool (Day, Bouchard, & Hsi, 2001) that determines eligibility for the program because of environmental risk issues such as a lack of basic needs and support networks, and concerns about the home environment, family substance abuse, and health and caregiver disposition. The project also uses a Legal Needs Assessment, developed by GRO (Norwood and Hanna, 1999), that identifies the legal needs of the family, and a FOCUS Risk Assessment tool (Schultz, Bouchard, Hale, & Bachofer, 2001) that helps the multidisciplinary team, as part of an ongoing assessment process, to consider areas of high risk and developmental outcomes with families. Additionally, developmental consultants utilize developmental and social-emotional instruments to assess a child's developmental status and provide parenting and developmental recommendations to the

case manager for use on home visits.

Although all the tools and strategies above are effective in helping relative caregivers identify, prioritize needs, and develop their own goals, the most effective method is case manager availability and continuity of care. If a case manager is not accessible or consistent in providing quality services, the family will most likely disengage.

Skills required of a case manager in working with relative caregiver families

Engagement. The engagement process can be the most important variable in working with any family, but is particularly relevant with relative caregivers. A case manager must demonstrate skills that allow the family to feel safe, unthreatened and genuinely capable of expressing their needs openly. It is the case manager's job to make sure that families feel supported and not judged, while maintaining a sense of professionalism and ethical boundaries. Initially case managers should inform the caregiver—through words and actions—that their primary role is to support the family by helping them meet their needs and address their concerns. Opinions and suggestions of the case manager should be withheld until the relationship is clearly established. Additionally a case manager can demonstrate support in many ways, e.g., simply responding to the family in a timely manner when they call, helping the family develop a plan of action, and focusing on the strengths of the caregiver or the family. Families can feel safe and supported in knowing that someone thinks positively about them, and this can help engage them in the process. Finally, clarifying expectations and responsibilities from the beginning is crucial to

establishing and maintaining a relationship with caregivers and families. All these characteristics allow trust to enter as a critical component of the relationship that emerges between them.

Empathic listening. Many relative caregivers have poor support systems and may just need to feel that their voice is being heard. Simply listening attentively may allow the family to feel that someone cares about their experience. Encouraged by this interaction, they may then be more receptive to joining a support group, where they can share their stories with others in similar circumstances.

Cultural sensitivity. Because the work of case managers increasingly extends into diverse communities, they must be sensitive to the interplay of the culture, language, and religious beliefs, since these affect how families make decisions. It is also highly beneficial if a case manager can speak the language of the family being served, understand or be aware of the cultural values that the family holds, and make a solid effort to learn about the family's culture to better understand the needs of the family.

PATRICIA: CASE EXAMPLE

When I first met Patricia, 45, grandmother and caregiver of four, I immediately knew that speaking English was a major barrier for her. Patricia seemed to get frustrated as she tried to explain in English the concerns she had about her family. Patricia had other family members present who spoke better English than she did and began to have them interpret what she was trying to say. Fortunately, I was able to communicate that I could understand and speak Spanish and the translation was unnecessary. Patricia suddenly jumped up from the chair she was sitting on, hugged me and began to address me as "mi hijita," an expression meaning "dear one" or "one who is like a daughter" in Spanish. Patricia and her family suddenly did not appear so tense and they began to speak to me as if I was one of the family. Language connected us from that day

forward and has allowed me to address the needs of the family more effectively. Patricia continues to benefit from this relationship in that she is able to utilize my help when she needs to ask questions and get clarity when dealing with community agencies regarding information she doesn't understand.

Humor is also a wonderful skill that can be quite effective in giving families the lightness that they rarely experience due to their stressful and sometimes burdensome responsibilities in caring for relative children. A case manager must be skilled in knowing when it is appropriate to incorporate humor and when it is not.

ROSE: CASE EXAMPLE

While meeting for the first time with grandmother Rose, I asked her to tell me about her family situation. Rose explained to me that she had been given custody of her four grandchildren, ages 2, 4, 5, and 9. She explained that the father was in prison and the mother's whereabouts were unknown. Rose's voice began to shake and her arms waved around anxiously as she began to explain: "The children bite me, hit me, cuss at me, scream at me, embarrass me, and…," she went on and on for what seemed like hours. "I just don't know what to do," Rose said to me. I did my best to assure Rose that I would attempt to help her locate the services she needed for her family. I could surely see how overwhelmed and stressed Rose was feeling and leaned toward her, smiled and said, " I sure bet you feel like running away sometimes don't you?" Rose laughed and the room suddenly didn't feel so heavy.

The use of humor with Rose alleviated the tension while allowing her to see the case manager's humanness and make a very important personal connection other than the professional role of case manager.

Flexibility is a required skill when working with relative caregivers. Case managers must learn to juggle their own schedules while addressing the child's needs, the needs of the caregiver, or that

of the extended family. An effective case manager must manage the child's medical, developmental, and social-emotional needs in parallel with the caregiver's legal, medical, financial and social support needs. (A real dilemma arises when the needs of the biological parents must also be considered, as described in the story of Raul, above.) Sound planning and a positive attitude is a definite asset when faced with the multiple layers of needs.

Sensitivity and awareness of the aging process. Although the average age of becoming a grandparent is relatively young, there still are many older grandparent-headed households (60 and older) who are caring for relative children. The age of a relative caregiver may determine the level of case management intervention needed. A good case manager must be aware of the effects on the aging process and should pay special attention to the individual needs of the client. For example, a relative caregiver over the age of 65 may suffer from hearing loss, have difficulty understanding information, and may function at a slower pace.

GLORIA: CASE EXAMPLE

Gloria, 66 and grandmother of five, was referred to the GRO Program four years ago when her son was incarcerated on drug charges and his girlfriend, mother of the target child, was unable to care for her child due to severe drug addiction. Gloria seemed to have difficulty remembering appointments and for the longest time continued to address me by the name of a previous case manager. Gloria was a feisty woman who loved and cared for her grandson dearly. When talking to her, one could see that she would appear to understand information given to her, but then later the same day she would call to have the information repeated one more time. I asked Gloria when she last saw her physician for routine medical care, learning that she hadn't been to the doctor in over 10 years and appeared to feel that she was healthy. I sug-

gested that she get a physical to assure that her health was in check because she was taking on quite a commitment in caring for her grandson and needed to stay in good health. Gloria agreed to get a physical and was found to have minor hearing loss. For over a year I continued to work with Gloria and developed a routine in which I would communicate information slowly and loudly, several times if needed, and write the information on paper for her because it seemed to help her organize her thoughts. I also helped her develop a planning calendar in her home to write down appointments.

Ability to engage children. To effectively work with relative caregiver families, a case manager must possess the skills to engage the children. A case manager must be able to play with children and communicate on their level. Simply getting on the floor and providing an opportunity to explore and observe a child's learning is essential. Since a main focus for GRO is on maximizing development and ensuring social emotional health, being able to observe and interact with infants or children is the best way to get first hand knowledge of how they interact with their world. The use of play and humor can also help to create a sense of comfort and trust with children, and it allows the family to learn from your example.

A final consideration: support for the case manager

Everyone knows that the world keeps changing. It is very important to keep current on grandparent/relative issues so that services can be adapted to the challenges they are facing at the present time. Policy makers continue to develop strategies to meet the needs of the kinship care population and it is important for case managers to become educated

(and educate the caregivers) on these matters. It is extremely important to attend trainings and conferences pertaining to the multi-generational populations being served. The more knowledge a case manager possesses, the better the clientele is served. Another advantage to this is that as one's knowledge base expands, one's confidence in maintaining quality service also increases. Education and training benefits everyone.

Case managers must also take care of themselves. As they become aware of the full extent of their job responsibilities, they must not attempt to provide services that are out of their scope of practice. Most importantly, referring the family to community resources to target specific needs is recognized as good case management practice.

Finally, working with families at risk can be a stressful and emotionally demanding job for case managers. It is crucial to their survival that they find healthy ways to relieve stress both at and outside the workplace. Taking breaks during the day, talking to a co-worker, or taking a short walk can help. When available, case managers should take advantage of gym incentives or employee workshops and classes. Doing one's best in this job means that when you go home at the end of the day, your job—and the families you serve—do not go home with you!

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integrity of the case managers should be guaranteed both during outreach activities and office hours, e.g., by doing home visits with two persons, and by not allowing male case managers to be alone with female clients.

PROVIDE SUFFICIENT RESOURCES FOR BOTH STAFF AND LOGISTIC SUPPORT

Sufficient resources should be available for both staff and logistic support to realize intended goals. The number of case managers should be proportionate to the total caseload—generally 8 to 12 cases per full-time case manager (Bool, 2002). Additionally, sufficient logistic support should be foreseen for the case managers, e.g. administrative support, office and meeting rooms, personal computers, cell phones (Oliva et al., 2001). Moreover, a reasonable budget should be provided for paying small expenses to clients, e.g. public transport, day nursery, baby food, clothing. As financial and child care issues have been identified as important barriers for entering treatment services among substance abusing mothers, such compensations seem to be well appreciated and might contribute to participation and retention in case management services (McLellan et al., 1999).

COMPOSE A MULTIDISCIPLINARY TEAM

Due to the multiple and interwoven nature of the challenges facing substance abusing families, a multidisciplinary approach is necessary and should include medical, psychological, social, and educational disciplines. The team also should consist of sufficient staff

with experience in the fields of substance abuse treatment and/or childcare (Bool, 2002). If such disciplines or experience are lacking, consultants can be added to the team. Weekly team-meetings promote a comprehensive approach, including referral to specialized services when necessary. A team-approach also allows smooth transfers from one case manager to another in case of a worker's temporary or permanent leave.

SELECT CASE MANAGERS WITH SUFFICIENT KNOWLEDGE AND SKILLS CONCERNING CHILD WELL-BEING AND SUBSTANCE ABUSE TREATMENT

For proper assessment, planning, monitoring and service delivery, case managers need extensive knowledge and psychological and educational skills concerning childcare and substance abuse treatment. Besides their qualifications, experience, skills and attitudes, case managers are expected to have good insight in the regional childcare, social welfare, mental health, and health care service systems (Oliva et al., 2001). Case managers are supposed to be boundary spanners, linking these services to other services with sometimes conflicting objectives, especially when the criminal justice system or child protection is involved.

ORGANIZE TRAINING AND SUPERVISION FOR THE CASE MANAGERS

As case management is a relatively new intervention including substantial similarities with already existing practices (Wolf, 1995; Siegal, 1998), training and supervision are required. Intensive training with follow-up is best provided

in small groups and should focus on the objectives, basic functions and principles of this intervention. Supervision should be directed at case managers' daily practice, questions and difficulties. Training and supervision will be of utmost importance when involving ex-drug users as role models or even case managers.

Conclusion

In several regions in the Netherlands and Belgium, brokerage and generalist models of case management have been implemented for helping substance abusing families. Based on available literature and empirical findings in both countries, several structural and content-related aspects of implementation have been identified as critical to the effectiveness of this intervention. These recommendations can be adapted and applied to case management interventions with substance using women and their families throughout the world.

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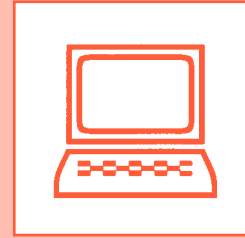
Treatment Improvement Protocol (TIP) Series 27

The series is comprised of 4 documents on case management for substance abuse treatment. The documents include a comprehensive overview, a clinician's version of the overview, and two 37-page concise desk references—one for administrators and one for treatment providers.

1998 and 2000. All documents are available free from SAMHSA Center for Substance Abuse Treatment. Ph: (800) 729-6686 or http://store.health.org/catalog. The original comprehensive document is available on-line at http://www.health.org/govpubs/BKD251/default.aspx

Home Visiting: Procedures for Helping Families, 2nd Ed.

This book includes theories of family development and interaction and adult problem solving, and relates them to the day-to-day practice of home visiting. A few issues addressed are managing and maintaining home visits, visiting families in stressful situations, and assessment and documentation in home visiting. Cost: $38.95

B. H. Wasik & D. M. Bryant, 2001. 322 pages. Available from Sage Publications. Ph: (800) 818-7243. Fax: (800) 583-2665. Email: orders@sagepub.com. www.sagepub.com

Getting Ready to Help: A Primer on Interacting in Human Service

This guide provides its readers with information on how to form relationships with clients, promote autonomy in individuals, create personal intervention plans, and find joy in the experience of helping others. It provides insight into communication, behavior, and human interaction. Cost: $19.95

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Beyond Technique in Solution-Focused Therapy: Working with Emotions and the Therapeutic Relationship

This book integrates the practical simplicity of solution-focused work with the presence of emotion and relationship. The focus is on how attention to emotional issues can help "unstuck" difficult situations and help pave the way to successful solutions. The book addresses theory, practice and applications. Cost: $33.00

E. Lipchik, 2002. 230 pages. Available from Guilford Publications, Inc. Ph: (800) 365-7006. Fax: (212) 966-6708. www.guilford.com

Family Solutions for Substance Abuse: Clinical and Counseling Approaches

This book provides clear models of diagnosis and intervention for families affected by substance abuse. A theoretical background on family systems is given, along with detailed case studies and figures. Cost: $24.85

E. E. McCollum & T. S. Trepper, 2001. 226 pages. The Haworth Press, Inc. Ph: (800) 429-6784. Fax: (800) 895-0582. Email: getinfo@haworthpressinc.com. www.haworthpress.com

Successful Problem Solving: A Workbook to Overcome the Four Core Beliefs That Keep You Stuck

The authors of this workbook suggest that the following four core beliefs keep people stuck: that they don't deserve to get what they want, that the world is too dangerous a place to risk a change, that they're too incompetent to solve their problems, and that others needs should come first. This book provides its readers with instructions in how to assess problems, brainstorm solutions, evaluate consequences, and develop an action plan to break through these beliefs. Cost: $17.95

M. McKay & P. Fanning, 2002. 176 pages. Available from New Harbinger Publications, Inc. Ph: (800) 748-6273. www.newharbinger.com

Infants, Toddlers, and Families: A Framework for Support and Intervention

This book provides a framework for strengths-based family intervention in the first three years of life. Chapters include approaches to working with disadvantaged children, children with disabilities, and "normal" children. The authors suggest planning and implementing interventions that work with each family's unique needs and resources. Cost: $20.00

M. Farell Erickson & K. Kurz-Riemer, 2002. 204 pages. Available from Guilford Publications, Inc. Ph: (800) 365-7006. Fax: (212) 966-6708. www.guilford.com

Therapeutic Family Mediation: Helping Families Resolve Conflict

This book is a practice-based text grounded in a therapeutic family mediation (TFM) model created by the authors. The book reviews the TFM model's five stages, outlines the use of parenting and financial plans, explores patterns of conflict and monetary issues, and discusses the importance of cultural diversity. Cost: $39.95

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The Batterer as Parent: The Impact of Domestic Violence on Family Dynamics

This book explains how partner abuse affects each relationship in the family, and how children's emotional recovery is linked to the healing and empowerment of their mothers. The authors provide a guide to evaluating change in the parenting of men who batter, assessing risk to children from unsupervised visitation, and supporting the emotional recovery of children. Cost: $32.95

R. Lundy Bancroft & J. G. Silverman, 2002. 256 pages. Available from Sage Publications. Ph: (800) 818-7243. Fax: (800) 583-2665. Email: orders@sagepub.com. www.sagepub.com

Growing Free: A Manual for Survivors of Domestic Violence

This 50 page book provides psychological insight and practical information to individuals who want to leave an abuse relationship, wonder

if they might be in one, or do not yet realize they are in one. It describes the effects of domestic violence on the victim and children in the household, offers safety information, and offers the reader helpful advice on how to build a healthy relationship with themselves, other people, and their children. Accompanying this, **A Therapist's Guide to Growing Free: A Manual for Survivors of Domestic Violence** is an 80-page book that provides the insight and therapeutic models needed for effective intervention and treatment, including: psychological effects and belief systems of victims and survivors; the effects of domestic violence on children and adolescents; the therapeutic challenges of couple therapy; handling crisis intervention; and safety planning. Cost: $14.95 for *Growing Free*, and $17.95 for *A Therapist's Guide*

W. S. Deaton & M. Hertica, 2001. The Haworth Press, Inc. Ph: (800) 429-6784. Fax: (800) 895-0582. Email: getinfo@haworthpressinc.com. www.haworthpress.com

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This collection of 20 articles examines topics that affect all counselors, including the dynamics of mixed and same race counseling relationships, and the dilemmas that confront counselors in addressing issues related to racism. Cost: $33.00

S. Palmer, ed., 2002. 280 pages. Available from Sage Publications. Ph: (800) 818-7243. Fax: (800) 583-2665. Email: orders@sagepub.com. www.sagepub.com

Depression: A Primer for Practitioners

This reference book for practitioners includes an introduction/refresher on depression that is research-based, practical and easy to read and consult. Chapters include symptoms

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Treating Chronic and Severe Mental Disorders: A Handbook of Empirically Supported Interventions

This book provides an array of evidence-based treatment models for schizophrenia, mood disorders, substance use problems and severe personality disorders. Modalities represented include cognitive-behavioral therapies, couple and family treatments, motivational interviewing, group work, and others. Cost: $50.00

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Theory and Practice of Brief Therapy

This text offers an overview of the "whys" and "hows" of brief therapy. The authors provide a framework for selecting and screening clients, rapidly finding a focus for clinical work, and making optimal use of available time. The final chapter is an edited case transcript that maps out an example of the authors' model of brief treatment. Cost: $25.00

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Handbook of Depression

This book offers in-depth coverage of the epidemiology, course, and outcome of depressive disorders; current issues in classification, assessment and diagnosis; vulnerability, risk, and models of depression; and effective prevention and treatment strategies. Issues of culture and gender differences, depression in children, and depression in later life also are addressed. Cost: $65.00

I. H. Gotlib & C. L. Hammen, Eds., 2002. 624 pages. Available from Guilford Publications, Inc. Ph: (800) 365-7006. Fax: (212) 966-6708. www.guilford.com

Your Depression Map: Find the Sources of Your Depression and Chart Your Own Recovery

This workbook helps readers create cus-

tomized depression maps based on their own personality and life style. Readers learn to identify the causes and symptoms of their depression, and then chart their personalized course of action for healing. Cost: $19.95

R. J. Paterson, 2002. 300 pages. Available from New Harbinger Publications, Inc. Ph: (800) 748-6273. www.newharbinger.com

A Woman's Addiction Workbook: Your Guide to In-Depth Healing

This book is for any woman seeking to explore an addiction problem. It offers motivational exercises that will help them to overcome their problems and break the cycle of "using to forget." The author helps her readers learn how to tolerate distress, endure being alone, reach out to others, express needs, and set boundaries. Cost: $18.95

L. M. Najavits, 2002. 196 pages. Available from New Harbinger Publications, Inc. h: (800) 748-6273. www.newharbinger.com

Chemical Dependency Counseling: A Practical Guide, 2nd Ed.

This manual combines the traditional twelve-step program with cognitive behavioral therapy and motivational enhancement. Chapters include: individual treatment, group therapy, special problems, adolescent treatment, and The Family Program. The second half of this manual is comprised of 55 appendices including steps one through five of the twelve-step program. Cost: $49.95

R. R. Perkinson, 2002. 541 pages. Available from Sage Publications. Ph: (800) 818-7243. Fax: (800) 583-2665. Email: orders@sagepub.com. www.sagepub.com

The Soul of Recovery: Uncovering the Spiritual Dimension in the Treatment of Addictions

In this book, the use of spirituality within several different treatment options is described, from the twelve-step program to programs tailored to the needs of addicted women and Native Americans. Personal accounts of how spirituality offered a means to recovery are presented by addicts, counselors, family members and doctors. Cost: $30.00

C. D. Ringwald, 2002. 320 pages. Available from Oxford University Press. Ph: (800) 451-7556. www.oup.com

CONFERENCE LISTINGS

Building on Family Strengths: A National Conference on Research and Services in Support of Children and Their Families

The goal of this conference is to showcase culturally competent, family-centered research and innovative programs and practices. The conference will feature paper and panel presentations related to improving services for families and their children who are affected by emotional, behavioral, or mental disorders. Participants will exchange information about family-centered research and program strategies, including family and/or youth involvement in all aspects of research and service delivery.

DATE: June 26-28, 2003
LOCATION: Portland, OR
SPONSORING AGENCY: Research and Training Center on Family Support and Children's Mental Health, Regional Research Institute for Human Services, Graduate School of Social Work, Portland State University
CONTACT: Alicia Magee. Ph: (503) 725-2785. Email: mageea@pdx.edu. Website: www.rtc.pdx.edu/pgConference.shtml

8th International Family Violence Research Conference

This conference provides an opportunity for researchers and practitioners from a broad array of disciplines to come together for the purpose of sharing, integrating and critiquing accumulated knowledge on family violence.

DATE: July 13 - 16, 2003
LOCATION: Portsmouth, NH.
SPONSORING AGENCY: The University of New Hampshire Family Research Laboratory & Crimes against Children Research Center

CONTACT: Sarah Giacomoni, Conference Administrator. Ph: (603) 862-0767. Fax: (603) 862-1122. Email: sarahg@cisunix.unh.edu

17th Annual Conference on Treatment Foster Care

At this conference, treatment foster care professionals will learn the most effective and cutting-edge techniques used in the field, network with experienced professionals from throughout North America, and exchange information and ideas with professional colleagues.

DATE: July 20-23, 2003
LOCATION: Universal City, CA
SPONSORING AGENCY: Foster Family-Based Treatment Association
CONTACT: Ph: (800) 414-3382 (ext. 113 or 121). Email: steller@mdu-inc.com. Website: www.ffta.org/conference.html

International Child and Youth Care Conference: Promise into Practice

This conference seeks to highlight the successful efforts of child and youth care, and to share these efforts across diverse cultures and disciplines. All forms of practice—direct care, supervision, education, research and policy-making—will be covered.

DATE: August 20 - 23, 2003
LOCATION: Victoria, Canada
SPONSORING AGENCY: International Child and Youth Care Conference, University of Victoria
CONTACT: Ph: (250) 721-6280. Fax: (250) 721-7218. Email: info@promiseintopractice.ca. Website: www.promiseintopractice.ca

Spirituality: A Powerful Force in Women's Recovery

The purpose of this symposium is to better understand the role that spirituality plays in the recovery process for women from various ethnic and racial backgrounds, and to help service providers integrate spirituality into their work with women in recovery.

DATE: September 15-16, 2003
LOCATION: San Francisco, CA
SPONSORING AGENCY: National AIA Resource Center
CONTACT: Margot Broaddus. Ph: (510) 643-7017. Fax: (510) 643-7019. Email: margotb@uclink.berkeley.edu. Website: http://aia.berkeley.edu

8th International Conference on Family Violence: Advocacy, Assessment, Intervention, Research, Prevention and Policy

This conference will bring together national leaders, researchers, and those working on the front lines with children, adult victims and offenders, to stimulate the formation of multidisciplinary solutions to end family violence.

DATE: September 16-20, 2003
LOCATION: San Diego, CA
SPONSORING AGENCY: Family Violence and Sexual Assault Institute (FVSAI), Children's Institute International (CII), and Alliant International University (AIU).
CONTACT: Lisa Conradi. Ph: (858) 623-2777 ext. 427. Fax: (858) 646-0761. Email: fvconf@alliant.edu. Website: www.fvsai.org

1st National Symposium Dedicated to Community Building and Child Welfare: Building Communities for 21st Century Child Welfare

This conference will highlight successful community collaborations that promote child well-being, and present policy trends and contemporary research pertaining to achieving community goals. Conceptual and skill building presentations will encompass trends, methods, strategies and successful developments in economic, health, education, housing, safety, occupational or other community resources on behalf of children and families.

DATE: September 22 – 24, 2003

LOCATION: Albany, NY

SPONSORING AGENCY: Child Welfare League of America (CWLA), Boston Children's Institute of The Home for the Little Wanderers, and the School of Social Welfare, University at Albany, State University of New York

CONTACT: Norah Lovato, CWLA, Program Manager of Behavioral Health. Ph: (202) 942-0301. Email: nlovato@cwla.org. Website: www.cwla.org/ conferences/2003cbsymposiumrfp.htm

Generations United International Conference

This conference is the largest international educational gathering for practitioners, administrators, government officials, and advocates interested in intergenerational approaches and solutions. The goal of the conference is to encourage creative programming and public policy initiatives that respect, value, involve and enhance the lives of people of all ages.

DATE: October 15 – 18, 2003

LOCATION: Alexandria, VA

SPONSORING AGENCY: Generations United

CONTACT: Generations United. Ph: (202) 638-1263. Email: gu@gu.org

Trapped by Poverty/Trapped by Abuse Research Conference

This conference brings together researchers, policy makers, service providers, advocates, and elected officials to learn more about these relationships, to explore effective policy responses, and to hear about innovative service delivery strategies.

DATE: October 17-19, 2003

LOCATION: Austin, TX

SPONSORING AGENCY: The Center for Impact Research, the University of Michigan School of Social Work, and the University of Texas School of Social Work

CONTACT: Ph: (773) 342-0630. Fax: (773) 342-5918.Email: cir@impactresearch.org. Website: www.ssw.umich.edu/trapped/conference.html

CWLA 2003 Conference: Tools that Work

The theme of this conference is how to improve child welfare services through research, performance measurement, and information technology.

DATE: November 12 –14, 2003

LOCATION: Miami, FL

SPONSORING AGENCY: Child Welfare League of America

CONTACT: Naomi Rau, CWLA. Ph: (617) 769-4003. Fax: (617) 770-4464. Email: nrau@cwla.org. Website: www.cwla.org/conferences/2003toolsrfp.pdf

Zero to Three: 18th National Training Institute (NTI)

This conference convenes the nation's multidisciplinary infant/family practitioners, educators, program administrators, researchers and policymakers to discuss the most critical issues affecting the development of children under three and their families, and to identify strategies for promoting best practices in infant/family services.

DATE: December 5 – 7, 2003

LOCATION: New Orleans, LA

SPONSORING AGENCY: Zero to Three

CONTACT: Zero to Three. Ph: (202) 638-1144. Website: www.zerotothree.org

new offense" (Pope, 2002, 54). While these results are promising and telling of the Bodega Model, the staff at Family Justice/La Bodega is currently creating a database that will ensure accurate outcome measures and constructive changes.

Conclusion

Family support seems logical. Yet our separation of policy and family has kept the idea of partnering communities with families, and families with government, from public service practice. Encouraged by the outcome of La Bodega's family case management work for substance abusers returning home from prison, Family Justice staff are continuing to test this concept in other settings. For example, The Department of Justice's Office of Drug Courts Program has long recognized the benefits of tapping the resources around substance abusers, but has struggled with implementation. We are now testing how to stimulate the incorporation of the family into adult criminal drug courts. La Bodega was cited in President Bush's 2002 National Drug Control Strategy as a promising innovation. It is our hope that policy makers and voters will recognize the value of tapping a natural resource, families, as they look towards a cost effective, politically charged, and socially valuable effort to break the cycle of addiction and criminal justice system involvement.

Carol Shapiro
Founding and Executive Director, and
Katie Sawicki,
Executive Assistant, Family Justice,
New York, NY

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■ Shared Family Care Program Guidelines (1996)	10.00	_____	_____
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