

SAMHSA NEWS

SAMHSA's Award-Winning Newsletter

Volume VIII, No. 4 Fall 1999

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Special Women's Issue

Youth track participants Lisa Sun Rhodes, from Poplar, MT (L), and Gina Watanabe, from San Jose, CA, represented the face of the future at SAMHSA's Second National Conference on Women, *Life Pathways: Women Healing, Thriving, and Celebrating*.



U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES
Public Health Service • Substance Abuse and Mental Health Services Administration
• Center for Mental Health Services
• Center for Substance Abuse Prevention
• Center for Substance Abuse Treatment

Editor's Note

This edition of *SAMHSA News* is devoted to the topic of women's health and welfare. It reports on selected proceedings from the Second National Conference on Women, "Life Pathways: Women Healing, Thriving, and Celebrating," cosponsored by SAMHSA with several other Federal agencies and departments. (See box below.) The conference took place at the end of June in Los Angeles, CA, and attracted more than 1,000 participants. This edition also describes some of SAMHSA's ongoing efforts to address issues of concern to women.

—*Deborah Goodman*

Conference Partners

Partnering with SAMHSA to host the Second National Conference on Women, "Life Pathways: Women Healing, Thriving, and Celebrating," were several agencies within the U.S. Department of Health and Human Services, including the Administration for Children and Families, Health Resources and Services Administration, Indian Health Service, Agency for Health Care Policy and Research, Health Care Financing Administration, National Institutes of Health, Office of Population Affairs, and Public Health Service Office on Women's Health. Other Federal partners included the Office of National Drug Control Policy, Executive Office of the President; U.S. Department of Housing and Urban Development; U.S. Department of Justice; U.S. Department of Labor; and U.S. Department of Education.

Women Shape a Vision for the 21st Century: A Message From the SAMHSA Administrator

Our goal at SAMHSA's Second National Conference on Women, held this past summer in Los Angeles, was exciting but challenging. As the conference subtitle, "Life Pathways: Women Healing, Thriving, and Celebrating," implies, our agenda was multifold: to celebrate the progress women have made, assess the current state of women's health and welfare, identify the many areas needing improvement, and articulate a plan and a strategy to make these improvements a reality in the new millennium.

This conference held a special significance for me—as the Administrator of SAMHSA and as a woman. It offered a rare chance to make a real difference, professionally and personally, in the lives of women.

More than 1,000 people from every state and several foreign countries, of all ages, races, life experiences, and professional backgrounds, gathered to pool our collective abilities to seek answers and find solutions.

Why the need for such a diverse gathering? Why the need now, at this particular point in time?

The 20th century has been a time of tremendous change for American women. We attained suffrage nationally with the ratification of the 19th amendment and entered universities and professions previously open only to men. The number of women employed outside the home also increased. According to a U.S. Department of Labor study released this past spring, in 1998 women earned approximately 76 percent as much as men did. In 1979,

when comparable earnings data were first available, the female-to-male earnings ratio was approximately 63 percent.

Yet, as women, we're still expected to shoulder the most responsibility as caregivers if one of our loved ones gets sick. We frequently juggle the greatest number of roles—and experience the most stress when we feel we have failed in any one of them.

Too many women's lives continue to be marred by the violence of strangers, acquaintances, and family members. Substance abuse among women of childbearing age continues to pose a public health concern, not only because of the long-term health hazards to women but also because of the threat to the well-being of their children. Too many women still experience financial need and must rely on public assistance, damaging their self-esteem and their belief in a better future.

So we cannot remain complacent as we enter a new century; too many tasks still lie ahead.

At the conference, with the generous assistance of our 15 Federal partners, we looked at women's lives in a multiplicity of areas: health care, family, housing, legal issues, employment, HIV/AIDS, and education, among others. Discussion of these crosscutting topics deepened our understanding of women in their totality and informed our plans for the efforts we must make together. A forthcoming report will provide detailed information on the conference proceedings.

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V i o l e n c e



Copyright Laura Prescott
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This collage was created by Laura Prescott, who served, until recently, as assistant project director at the SAMHSA-funded Women, Co-Occurring Disorders, and Violence Study Coordinating Center in Delmar, NY. (See p. 5.) Ms. Prescott recently launched her own consulting firm, "Sister Witness." She continues to produce art that reflects her understanding of the impact of violence on women.

Americans overwhelmingly agree that we live in a violent society. Few, however, realize the full toll that violence exacts from American women—or how inadequate the services have been for many of them.

In fall 1998, the first National Violence Against Women Survey, sponsored jointly

A National Problem, **A National Response**

by the U.S. Departments of Justice and Health and Human Services, revealed that nearly 2 million women are physically assaulted annually in the United States. Yet the severe and long-lasting emotional effects of assault and rape have frequently been unacknowledged, misunderstood, or overlooked, not only by society as a whole but also by those who provide treatment to women with mental and addictive disorders.

Several lines of research have recently converged to provide new insight into the phenomenon of violence against women. Experts now recognize such violence as both a problem of immense scope and a critical factor in the mental or addictive problems that many women suffer.

There is a growing consensus that the role of violence in the emotional or addiction problems of women has received too little attention from the professionals and facilities that are supposed to serve them. Instead of considering trauma as an independent and sometimes causative factor, treatment providers in the fields of mental health and substance abuse have traditionally focused on ameliorating the symptoms of such conditions as

depression, anxiety, and panic attacks. Advocates for women say that practitioners have frequently failed to recognize that symptoms such as emotional withdrawal, dissociation, or risk-taking may actually be mechanisms for coping with the distress caused by trauma. In many such cases, failure to discern the underlying source of a woman's distress unwittingly worsens her condition.

Studies show that women coping with violence and co-occurring mental and addictive problems also face numerous obstacles in obtaining treatment for their multiple issues. The treatment systems dedicated to each type of problem—violence, substance abuse, or mental disorders—are organized separately. Each system has staff educated and trained to deliver services for only one type of problem and may use incompatible approaches.

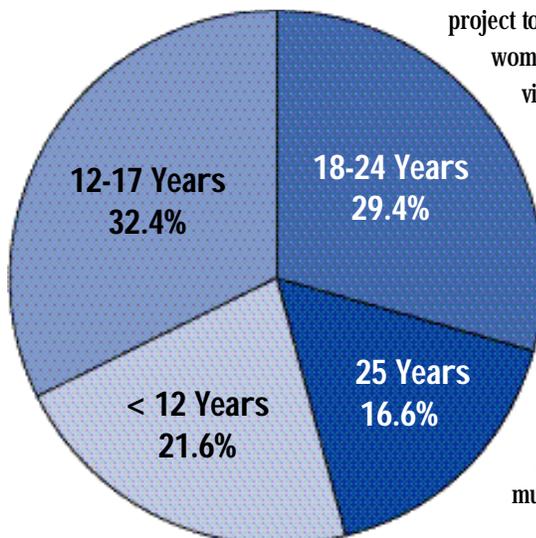
Childhood sexual abuse may also contribute to later mental and addictive problems, many observers have suggested. In addition, the experience of trauma from trusted intimates, such as family members and friends, complicates law enforcement and prevention efforts because young victims rarely bring their attackers to justice and may not even speak of the crime to anyone else, often keeping it a supposedly shameful secret for years or even decades.

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Scope of the Problem

According to the 1998 report, *Prevalence, Incidence, and Consequences of Violence Against Women: Findings From the National Violence Against Women Survey*, more than half of the adult women questioned reported physical assault at some time in their lives. Eighteen percent of the women surveyed said that they had undergone an attempted or completed rape, and 8 percent reported being stalked at some time in their lives. Very young women and girls are at highest risk of rape, with more than half of reported first rapes happening before the girl reached age 18 and 22 percent before age 12.

The results documented a distinctively female pattern of victimization, carried out overwhelmingly at the hands of males, most often someone the victim knew well. Husbands, boyfriends, or dates perpetrated three-quarters of the rapes and assaults against adult women reported in the survey.



Women Victims' Age at Time of First Rape^a

a. n=1,323 women victims

Source: *Prevalence, Incidence, and Consequences of Violence Against Women: Findings From the National Violence Against Women Survey, 1998*

Federal Response

In recent years researchers and policymakers in the fields of criminal justice, mental health, addiction treatment, and substance abuse prevention have come to a common insight: The Nation needs a new approach to violence against women that recognizes it as both a major public safety problem and a critical issue in the physical and mental health of women as individuals.

In response, the Federal Government has undertaken a wide-ranging effort, spearheaded by Health and Human Services Secretary Donna Shalala and Attorney General Janet Reno, to alert the Nation to the issue and to develop strategies that curb violence against women and that help its victims. As mandated by the Violence Against Women Act of 1994, a national advisory committee that reports to these two Presidential Cabinet members is working on a national agenda on the issue.

SAMHSA has also undertaken a major project to find the best ways of serving women who have experienced violence or trauma and have mental and addictive problems. (See *SAMHSA News*, p. 5.) The topic also figured prominently at SAMHSA's recent National Conference on Women held this summer. (See *SAMHSA News*, p. 9.) The accompanying articles give details of SAMHSA's multifaceted approach. ▶

"Vision" continued from page 2

At SAMHSA, where our mission is to improve the lives of people affected by mental and addictive disorders, we have a special opportunity to help women whose lives have been touched—directly or indirectly—by these problems. In addition to selected conference reportage, this issue of *SAMHSA News* offers information about some of the unique services, resources, and programs SAMHSA offers to people seeking help or working for change. It continues the dialogue started at the Second National Conference on Women and provides a tool to help maintain the momentum of our efforts—a momentum we cannot afford to lose.

We have a responsibility to leave the world a better place for the women who follow us. They are the ones whose lives will be most affected in the next century by the actions we have taken in this one.

Our recent conference included a special track for youth to ensure that they could explore the topics of greatest importance to them and could express their views freely. Their insightful ideas and innovative suggestions are their gift to us; our thoughtful consideration and prompt response should be our legacy to them.

With the conference, women from across the country staked a claim to help shape their own future health. Our success depends on the effort and commitment that we, as individuals, make.

I urge each of you to bring your own time, expertise, and energy to ensuring progress. You are our most valuable resource. Working together, we can lay the foundation to build and celebrate a new century of progress for women. ▶


Nelba Chavez, Ph.D.

Violence Against Women

SAMHSA's Response

"Women may heal on one level, but not heal on another," says Janet Schulman, M.S.W., M.P.A., and without attention to the whole woman, she says, treatment will most likely fail.

Ms. Schulman serves as program director of PROTOTYPES Systems Change Center, a Los Angeles agency serving women with mental and addictive disorders who also have suffered physical and/or sexual abuse and their children.

The confluence of these problems lies at the heart of a new, SAMHSA-funded study called the "Cooperative Agreement To Study Women With Alcohol, Drug Abuse, and Mental Health Disorders Who Have Histories of Violence," or the "Women, Co-Occurring Disorders, and Violence Study" for short. The 5-year study seeks to identify and test the most effective ways to offer integrated services for problems more often treated with disparate solutions. All three of SAMHSA's Centers are participating in the project.

Research suggests that integrating treatment for mental, addictive, and trauma-related problems into a carefully organized, seamless whole should offer the best chance for recovery for women with co-occurring disorders. Yet, finding effective ways of integrating these services requires overcoming historical and bureaucratic barriers.

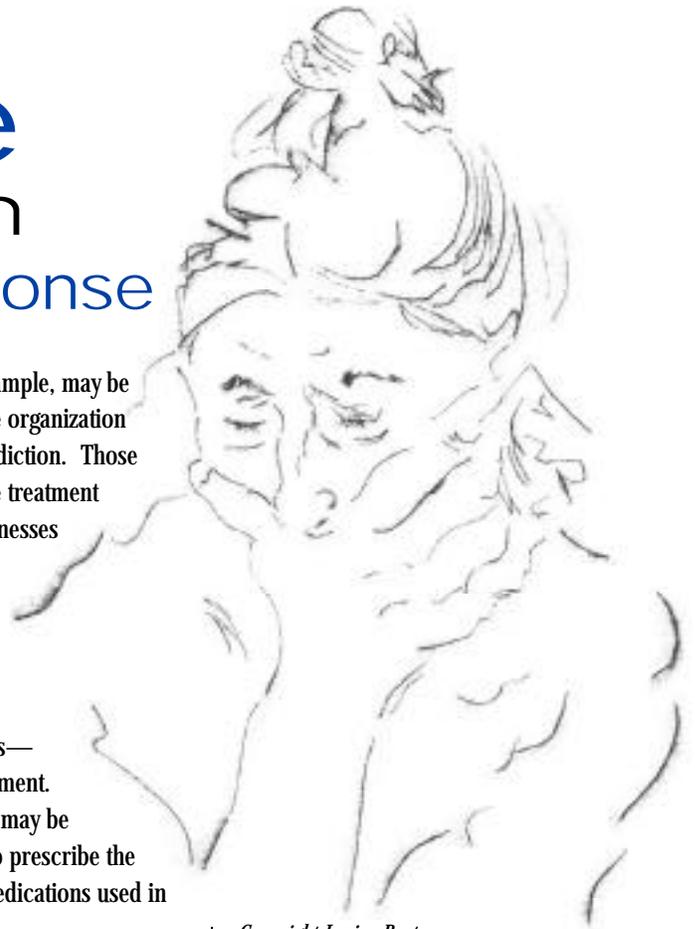
Many agencies that work with clients have a single focus. A woman seeking admission to a homeless or battered

women's shelter, for example, may be turned away because the organization cannot deal with her addiction. Those seeking substance abuse treatment who also have mental illnesses may find themselves rejected by treatment centers philosophically opposed to the use of any drugs—including prescription medications—in substance abuse treatment. Or the treatment facility may be medically unequipped to prescribe the special, psychotropic medications used in treating mental illnesses.

Breaking the cycle of shuttling between single-focused agencies may hold the key to solving the conundrum of interwoven mental, addictive, and trauma-related problems.

To test the true effectiveness of integrated services, and to find the most effective ways for agencies across the country to provide them, the Women, Co-Occurring Disorders, and Violence Study involves 14 participating organizations (also called "study sites") as well as a coordinating center in Delmar, NY, to collect and analyze data.

"Current systems of care do not adequately address co-occurring disorders in women," says Melissa Rael, R.N., project officer for the study at SAMHSA's Center for Substance Abuse Treatment. "Appropriate treatment is an even greater problem when



*Copyright Jessica Barton
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This portrait of her mother is from an etching by professional artist and graphic designer Jessica Barton, a self-identified survivor of alcohol and other drug abuse and trauma. Ms. Barton is a project consultant at the Women and Mental Health Study Site of Dane County in Madison, WI, one of the projects participating in the SAMHSA-funded Women, Co-Occurring Disorders, and Violence Study. "We were both abused." Ms. Barton says, speaking of herself and her mother. "Reproducing her image through art was a way of staying connected to her."

these women have been traumatized. Moreover, they rarely have adequate care for their children or for a multitude of other complex personal, social, financial, and health problems. We must create integrated services that work for these women and their children."

The sites serve an array of clients as diverse as the Nation itself. They include

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rural and urban agencies in a variety of regions and populations, such as migrant farm workers, prison inmates nearing release, women who sell sex for money, HIV-positive women, refugees, immigrants, homeless women, and other groups.

The study grows out of SAMHSA's longstanding concern for improving services and treatment outcomes for women.

In the mid-1980s, SAMHSA's Residential Treatment for Women and Children grant program tested the hypothesis that substance-abusing women with children would recover more readily if their children were permitted to live with them in the treatment setting. However, what emerged from the study went beyond this: Findings showed effective treatment for women required attention to their children's pressing physical and psychological problems as well. Also, the issues of trauma and violence kept surfacing in ways that could not be ignored.

"In the wake of a traumatic experience, a woman is very likely to develop symptoms such as depression or anxiety and is very likely to self-medicate," says Susan Salasin, director of the women's mental health program at SAMHSA's Center for Mental Health Services. This can contribute to chronic substance abuse.

Conversely, preexisting mental health or addiction problems may make a woman more vulnerable to violence.

Despite the central role of trauma in many women's mental and addictive problems, Ms. Salasin says, "psychiatry and [the] substance abuse [field] have not known how to deal with or have basically ignored the important role of physical and sexual abuse in the lives of women, not asking about it, not believing it. Therefore, it has never been part of treatment."

Treatment aimed at the fallout of violent victimization therefore needs to be part of the array of interventions provided to affected women.

Working Collaboratively

The goal of the Women, Co-Occurring Disorders, and Violence Study is to find better ways to provide comprehensive care to women who seek treatment for substance abuse, mental illness, or violent trauma but who are affected by all three.

Providing appropriate care requires, first, that all types of "agencies and caregivers look for signs of each type of problem, even those their own organization may not have the expertise to treat, and second, that agencies develop effective means of getting each woman the help she needs," says Norma Finkelstein, Ph.D., executive director and principal investigator at the Institute for Health and Recovery, a Women, Co-Occurring Disorders, and Violence Study site in Cambridge, MA.

If, for example, a woman makes her first contact with a substance abuse treatment agency, Ms. Rael says, "while undergoing detoxification and treatment, the woman's treatment plan should include an assessment for mental and trauma-related problems. After the assessment, if there is an indication of need, the next step is to arrange for the appropriate blend of treatment services, either at the treatment center or by coordinating the services of providers at different locations."

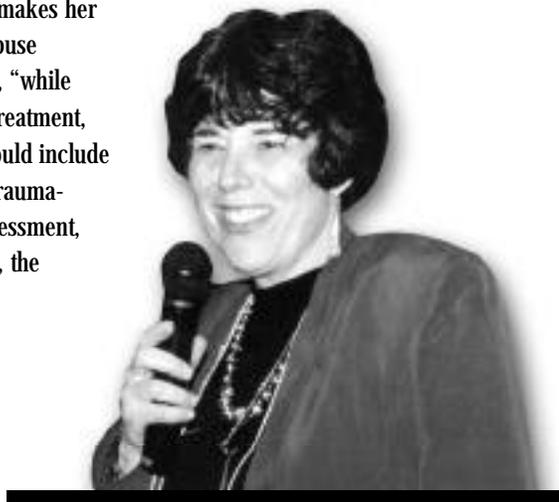
Such assessments will take sensitivity and skill. Trauma victims, for example, may exhibit symptoms that,

in Ms. Salasin's words, "very much mimic symptoms of schizophrenia or severe depression." But a history of trauma, and even painful feelings or behaviors relating to the experience, do not necessarily indicate that a woman has a pervasive, deep-seated mental disorder.

In the case of sexual abuse long hidden as a shameful secret, "you'd be surprised how many people will respond if they perceive that the questions are being asked in a supportive and thoughtful way," Ms. Salasin says.

Doing this kind of multilayered assessment therefore requires cross-training for care providers in several disciplines because the mental health, addiction treatment, and trauma recovery fields each has its own history, professional culture, and intellectual framework.

But determining that a woman has multiple problems is just the beginning. Care providers then need ways of providing the whole range of necessary



Norma Finkelstein, Ph.D., is executive director and principal investigator at the Institute for Health and Recovery, a participating study site in Cambridge, MA. She also serves as chair of the steering committee for all participants in SAMHSA's Women, Co-Occurring Disorders, and Violence Study.

services, a goal vastly complicated by the bureaucratic and logistical requirements of enrolling, funding, and moving clients among several distinct agencies, each used to its own procedures and each located in a different place.

“The process of being shuffled between many different treatment centers for specialized help and constantly starting over with new staff is overwhelming and counterproductive for many women with serious disorders,” Ms. Schulman says. Many simply get lost between agencies and drop out of treatment.

Having to go to various places for different services is “really hard, [especially] when you have kids and you have to get on the bus and you’ve got to be somewhere at a certain time and you’re tired,” says a participant from one of the study sites who, for 17 months, has received treatment for intertwined mental, addictive, and trauma issues. Formerly homeless and addicted to cocaine and alcohol, she was also facing both prison time for felony narcotics distribution and the permanent loss of her five children. She is now a clean, sober mother caring for all her children at home and serving as a consumer advisor to her treatment agency, one of SAMHSA’s Women, Co-Occurring Disorders, and Violence Study sites.

Crucial to her success, she believes, is that her treatment program could provide and organize everything she needed. “It made a real big difference . . . [to] go to my treatment center [and] . . . have everything that I need Every day of the week I was doing something different . . . I was on a schedule, I could do what I had to do, but all I had to do was get to one place to do it. They would pick me up and drop me home. They would even pick



SAMHSA project officers (l. to r.) Melissa Rael, R.N.; Jeanette Bevet-Mills, M.S., M.Ed.; Susan Salasin

the kids up for school and bring them back. I’ve had parenting [training], family therapy, mental health therapy in a group setting and also individually and alcohol and drug sessions.”

Also crucial to her recovery was the hope—and, ultimately, the reality—of beginning to resolve the painful issues surrounding her children.

“A woman’s children play such an important part in the mother’s whole sense of well-being and even her recovery,” says Jeanette Bevet-Mills, M.S., M.Ed., of SAMHSA’s Center for Substance Abuse Prevention. Especially for women whose condition has caused them to lose custody of their children, “there is grief and loss that go along with children being removed, whether permanently or temporarily.” (See *SAMHSA News*, p. 18.)

In the families of women with co-occurring disorders involving substance abuse and violence, addiction is often “self-perpetuating [across generations] if there isn’t something to interrupt the cycle,” Ms. Bevet-Mills says. The Center

for Substance Abuse Prevention, therefore, emphasizes that training programs for parenting skills be available to all clients, be they women whose children are with them, women whose children have been removed, or as-yet childless women who may someday become mothers.

“Positive changes in the lives of the mothers, we hypothesize, will have . . . a positive impact” on children, Ms. Bevet-Mills says.

The Study

The task of learning how to bring coordinated help to women with complicated problems “itself is complicated,” says Dr. Finkelstein, who also serves as chair of the steering committee representing all the Women, Co-Occurring Disorders, and Violence Study’s participating entities.

“Integral to the project’s every aspect are Consumer/Survivor/Recovering persons (C/S/Rs),” like the study participant described earlier, “who serve at both the local level and on the project’s national

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Members of the staff of PROTOTYPES Systems Change Center, one of the SAMHSA-funded study sites (l. to r.): Paula Bjelajac, a self-identified "consumer/survivor/recovering person," data coordinator Tina Henderson, and program director Janet Schulman, M.S.W., M.P.A.

steering committee," says Ms. Rael. "In this study," she adds, "C/S/Rs are women who are consumers of services for substance abuse, mental health, and trauma, who have survived the violence and trauma, and [who] are recovering. Their willingness to share their experiences provides a valuable contribution and enhances the significance of this study.

"Their personal stories and recommendations inform service providers, clinicians, and researchers about gaps in treatment and other services as well as about what works best," Ms. Rael continues. "This information in turn is incorporated into the development of the cross-site evaluation protocol and [is] integrated into the service delivery system. Women are learning to become empowered and are given the opportunity to have a voice and a role in their treatment."

Composed of representatives from all three SAMHSA Centers, the study sites, the coordinating center, and the consumer

advisers, the steering committee will "guide the project and make decisions" during the study's two stages, Dr. Finkelstein continues. First comes a 2-year development period, now under way, during which the sites, in conjunction with the Federal sponsors and coordinating center, are developing models of service integration that they will test during the 3-year phase that will follow.

Many approaches to organizing services will be tried to see which work and which do not. "All will emphasize an approach that supports the integration of services for mental, addictive, and trauma-specific problems into a seamless support network for women and their children," Ms. Rael says.

This type of approach may include such strategies as using case managers to see that each client's care plan is properly carried out or colocation of services, in which a staff member from one agency spends specified periods providing services on another agency's premises.

A variety of different approaches will be used. Each site will solve its particular logistical challenges, be they transporting people in rural areas that lack mass transit; providing a sense of security and continuity in dense, threatening, inner-city neighborhoods; or meeting the special linguistic and cultural needs of particular ethnic groups. As the model-development phase proceeds, the sites will also cooperate in a combined effort to develop overarching intervention models useful and testable at all the sites.

This will be followed by a 3-year period in which the intervention models are put into action and evaluated on multiple levels for delivery and results. First, the study will assess "how difficult is it to set up an integrated system within each community?" Ms. Schulman explains.

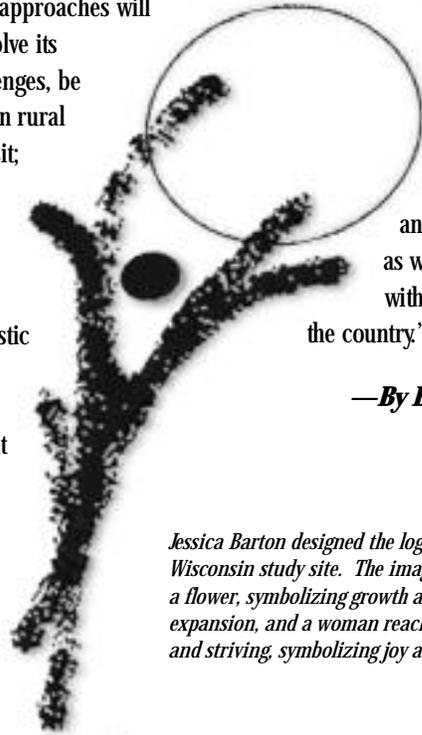
Sites will also evaluate "the outcome [for] the client," she continues. "Does it make any difference that you've got this integrated setting, that people are finding it easier to get treatment? Are the outcomes for clients any better than they were when they were in a system that wasn't as seamless?"

Each study site, as well as the coordinating center, will be required to prepare reports describing the challenges encountered and the solutions tested.

"There is a compelling need to chart new directions in dealing with the complex interaction of violence, substance abuse, and mental disorders," says SAMHSA Administrator Nelba R. Chavez, Ph.D. "We intend for

this Women, Co-Occurring Disorders, and Violence Study to do that and, when we have some answers, share these as widely as possible with programs throughout the country." ▽

—By Beryl Lief Benderly



Jessica Barton designed the logo for her Wisconsin study site. The image is both a flower, symbolizing growth and expansion, and a woman reaching and striving, symbolizing joy and hope.

Conference Highlights

Societal Context of Violence



Panelists (l. to r.) Vivian Brown, Ph.D., Vickii Coffey, MA., and Carol Warshaw, MD.

Preventing violence against women and helping those affected requires more than providing treatment, speakers agreed at a plenary session on violence at SAMHSA's recent National Conference on Women. The societal conditions that permit and condone abuse also must change.

As plenary moderator Sheila Wellstone, an advocate for battered women and wife of Senator Paul Wellstone (D-MN), observed, "Domestic violence has moved far beyond being a private matter. Violence in our homes is spilling into our streets, into our neighborhoods, into our communities. It's affecting our health care system, our law enforcement and judicial



Panel moderator Sheila Wellstone

system, and our human services system. It requires a response from each of those working with battered women's advocacy programs.

"The passing of the Violence Against Women Act was a very significant event for battered women and victims of sexual assault in this country," Mrs. Wellstone added. "For the first time, the Congress of this country said that violence against women was a crime and that it would be treated as such."

Speaker Carole Warshaw, M.D., co-director of the crisis intervention project at Cook County Hospital in Chicago, IL, said, "Instead of seeing assaults and their emotional aftermath as incidents happening to particular persons, service providers need to regard them in terms of a 'social model' that permits such physical abuse and forces women to 'adapt to [a] traumatic social context.'"

Training traditionally teaches clinical professionals that when "people present with symptoms, we diagnose disorders and we treat pathology," she continued.

For example, she cited records from a hospital emergency room in which

"women would describe a recent episode of abuse, and what would happen was they would get a psychiatric diagnosis . . . like adjustment disorder with anxious mood—'She had trouble adjusting to being beaten, so she was anxious'—and she'd be given benzodiazepines and referred to a mental health center . . ."

Many treatment providers still perceive "women's survival strategies as disorders rather than as ways to survive intolerable situations," Dr. Warshaw said. Professionals now "need to reframe the depression, the substance abuse, the denial, [and] the dissociation as women's attempts to deal with feelings that are intolerable" when the person under attack cannot "change the external conditions" creating the emotions.

Abused women with serious mental or addictive problems need effective, long-term treatment, she emphasized, but also noted that "the real public health problem" is the "normative social pathology" that forces women to "chronically adapt to trauma."

Traditionally, "batterers have . . . social permission to batter," she said.

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Men who assault women often have personality problems and addictions, but “they don’t batter their bosses, [and] they don’t batter their neighbors.” They only “batter the person that they feel is a legitimate target”: a woman.

The next speaker, Vickii Coffey, M.A., of Vickii Coffey and Associates, a consulting firm specializing in domestic violence issues, related personal experiences that mirrored in many ways, and on an individual level, the more global picture painted by Dr. Warshaw.

She recalled that she had endured long periods of abuse but “[I] didn’t recognize, nor did I understand, that I was experiencing this victimization in concert with other women.”

On one of her repeated emergency room visits, “after 8 years of abuse, after seeing doctors in different hospitals and . . . seeing people like my minister and close friends,” a doctor finally asked her, “Who did this to you?” rather than the usual “How did this happen?” This “turning point” in Ms. Coffey’s life “took away the implication that I was doing this to myself. Someone was doing it to me.”

The next time her abuser attacked, Ms. Coffey fought back. But when she called the police they began to “rough me up,” she said. She resisted and soon found herself committed to a locked psychiatric ward.

After many difficult hours, some spent in restraints, Ms. Coffey encountered a nurse’s aide who told her, “You didn’t have a nervous breakdown; women come here all the time like this. Police bring them here just to break up a fight.” Though she stayed on the ward for 3 days, a transformation had occurred when the aide “validated and affirmed what I was

going through and called it what it was: his abuse, not mine.”

“Service providers must change the systems in which they work,” said the fourth panelist, Vivian Brown, Ph.D., president and chief executive officer of PROTOTYPES, a Los Angeles agency serving women with mental and addictive disorders who also have suffered physical or sexual abuse.

“We made a commitment, those of us who are service providers, to first do no harm. But when a drug treatment program will not take a woman who self-injures, when a battered women’s shelter will not admit a woman with substance abuse or mental illness, when a mental health treatment program will not see a woman with severe mental illness with her children, when a medical provider speaks disrespectfully to a pregnant woman because of her substance abuse or doesn’t listen to [a] woman who is attempting to discuss the abuse she experienced in our institutions because she is ‘crazy,’ then our systems and programs are doing harm . . . We can no longer do business as usual . . . let us change the systems now.”

The final speaker, Leah Aldridge, director of a youth violence prevention program in Los Angeles, said, “In dealing with our youth today, we have to draw connections and intersections between all the issues that [affect]” them, including such diverse ones as gangs, the juvenile justice system, and school dropouts involved in violence. Many abused girls and young women, for example, “will not involve law enforcement when it comes to partners because they do not want to see their men, especially their men of color,” at risk for incarceration. Instead, they “stay in that potentially lethal relationship.”

“Strategies that work with adult women do not necessarily work with teens and adolescents,” she observed. Adults, therefore, must become “allies” who help develop “leadership among teens because lots of studies show that young people will talk to their peers rather than talk to a counselor or other adult professionals.” The goal must be “to empower young people to be leaders among themselves,” she concluded. ▶



Leah Aldridge

An Artful Approach to Change

Suzanne Lacy, an internationally known performance artist, presented slides of her work at the Second National Conference on Women. Ms. Lacy was Dean of the California College School of Fine Arts and Crafts for 10 years. Her work addresses a broad range of social and political needs, and through her art and writing, she supports activism, audience engagement, and a role for artists in shaping the public agenda.

At the conference, Ms. Lacy spoke about one of her most recent works, *Auto: On the Edge of Time*. An art project on family violence spanning 2 years and several sites across the country, it consists of a series of cars transformed into sculptural representations. The cars were created by women and children who were abused by loved ones.

"The metaphorical relationship between battered cars and lives wrecked by abuse is a powerful one," Ms. Lacy said. "For some, the cars symbolized the means to escape. For others, they were road maps to the damage of their bodies. But all remember the times they were stalked by, dragged into, tied up in, thrown from, and assaulted in cars."

Participants included women from a domestic violence shelter in Pittsburgh, PA, women from a family violence program at Bedford Hills Correctional Facility in Bedford Hills, NY, children from shelters in Niagara Falls, NY, and Cleveland, OH, and teenage girls in Oakland, CA, and on Staten Island, NY.

Eight cars were stripped of motors, gas tanks, batteries, and interiors and were sealed to prevent entry. The women further altered the cars by adding language and objects to form a profound testimony to their own experiences. ▀



- * *Three cars were created at the Bedford Hills Maximum Security Correctional Facility in August 1993 in upstate New York by 15 women in the family violence program.*

The Abuse Car: *The interior of this large, white car has been transformed into a distorted house—an easy chair and corner of a bed, dish shelves in the back window, and a stove top on the dashboard. On furniture and household items, phrases describe the various forms of violence women and children have experienced. On the iron, for example, is written "Held hot iron to my leg." The car becomes ominous; phrases on the outside relate the automobile to violence, for example, "Chased by a car without headlights" (developed in Bedford Hills, NY).*



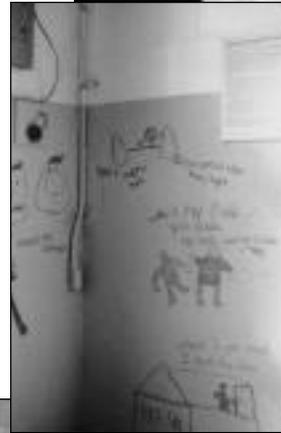
- * **The Healing Car:** *Most of the windows of this wrecked car are covered with mesh. On those that are not, one can view an interior that looks like a woman's dresser or shrine, filled with photos, made objects, and other memorabilia that represent the women's aspirations toward a better life (developed in Bedford Hills, NY).*

"Surprisingly, in an era when prison movies and television news portray hardened and often brutal inmates, these women are compassionate and astonishingly wise," Ms. Lacy said. "They become our teachers as we see through their eyes the impact of sustained abuse, including their eventual incarceration."

- * Suzanne Lacy



- * **Installation at Niagara Falls:** *In October 1993 the cars were exhibited at a gas station in Niagara Falls, NY, under the auspices of Artpark and the Public Art Fund. Inside the gas station, children's drawings of domestic violence were drawn directly onto the walls of the garage.*



- * **The Brick Wall Car:** *The interior of this small station wagon is filled with a solid brick wall. Embedded in the bricks are objects from the prisoners' past lives, for example, high heels, handcuffs, or hypodermic syringes. Several bricks are inscribed with women's prison sentences. Etched into the glass windows are the stories of times they went for help and were failed by people in the various systems they approached (developed in Bedford Hills, NY).*

From Welfare to Work

Overcoming Mental and Addictive Obstacles

On August 22, 1996, the landscape of welfare within the United States was dramatically transformed. No longer would people be entitled to Federal assistance based solely on need. "The Personal Responsibility and Work Opportunity Reconciliation Act of 1996" set up a system that offers time-limited assistance and requires work.

The Temporary Assistance for Needy Families (TANF) program replaced the former Aid to Families with Dependent Children and the Job Opportunities and Basic Skills Training programs. Federal funds can now be used to assist families for no longer than a lifetime total of 60 months. (States may choose shorter lifetime limits.)

After 24 months, every participant who has received TANF benefits and who does not have a hardship exemption must work. Again, states may require work within a shorter timeframe.

In addition to the profound implications for TANF recipients, the law also requires states to meet specific goals. Each state is required to have a work participation rate of 50 percent among TANF recipients by the year 2002.

That will not be easy. TANF recipients often have problems such as substance abuse and mental illness that complicate moving from public assistance to paid employment.

Most studies estimate that between 10 to 20 percent of welfare recipients have some substance abuse problem, according to Laura Feig Radel, M.P.P., a senior social science analyst in the U.S. Department of Health and Human Services,

Office of the Assistant Secretary for Planning and Evaluation.

"A lot of the variation stems from differences in the definition of what constitutes an alcohol and drug 'problem,'" she says. "Some studies consider addiction to be the defining factor, whereas others measure the problem by any past-year drug use."

Sharon Amatetti, a public health analyst at SAMHSA's Center for Substance Abuse Treatment (CSAT), says a variety of barriers connected with substance abuse make it difficult for clients to move from public assistance to paid employment. TANF case workers are not treatment providers, tend to lack knowledge about substance abuse generally, and tend to view treatment as a punitive measure rather than a medical intervention.

Typically, Ms. Amatetti says, an applicant for public assistance is confronted about her substance abuse in an environment that does not foster honesty. An applicant may be asked, "How many days in the past 30 have you used cocaine?" Given no assurance that the truth will not be held against her, not surprisingly, the client is unlikely to volunteer information about substance abuse. There are other reasons she will rarely do so.

"There is a lot of denial associated with addiction, a lot of stigma, and a lot of fear, primarily among women heads of households who risk losing their children to child protective services," Ms. Amatetti says. "One of the most difficult issues that all the states are grappling with is how do we identify that portion of the caseload that has alcohol and drug problems."



Traditional urinalysis is “very invasive,” playing into clients’ fears, says Ms. Amatetti. It detects only more recent drug use, fails to detect alcohol abuse, and is expensive.

Other problems further complicate the transition from public assistance to paid employment. TANF case workers are not trained treatment providers for mental disorders and may be unable to identify or refer clients for help with such problems.

Clients with young children cannot leave them unattended while the clients are at work or training, yet they also cannot afford child care. The children themselves may have their own emotional problems resulting from the difficult environments in which they live. Welfare clients frequently do not own cars and often live in areas with poor public transportation, impairing their mobility to work sites and treatment centers.

When the 1996 Personal Responsibility and Work Opportunity Reconciliation Act was passed, several provisions raised concerns among welfare recipients, advocates, treatment providers, and other stakeholders. The law allows states to test TANF clients for illegal drugs and to impose sanctions on those who test positive. It also prohibits states from furnishing cash assistance or food stamps to those who have been convicted of drug felonies since the law was signed, although states are allowed to pass legislation to opt out of this requirement. Some stakeholders view this as a punitive approach that is more likely to scare off clients who are potentially productive citizens from getting the help they need.

Finally, individuals whose disabilities stem primarily from substance abuse no longer qualify for Supplemental Security Income disability benefits.

SAMHSA grantee Richard Speigman, D.Crim., a senior research scientist at the



Public Health Institute in Berkeley, CA, who presented at SAMHSA’s recent National Conference on Women, frames the issue this way: “As the TANF reforms were introduced, estimates were that no more than 20 percent of the caseload of adult recipients would need to be exempt from work requirements or welfare time limits. The rest presumably would become employed. Thousands of former welfare recipients are now off the welfare rolls. Advocates, researchers, policymakers, and news analysts have expressed concern about where departing TANF clients have ended up and why. Not much is known. The common question seems to be, how are they doing financially? And we don’t even know the answer to that question, let alone how are they doing in the rest of their lives.”

SAMHSA is trying to track the effect of the law on people moving from public assistance to paid employment and on the areas of concern that stakeholders have raised.

Although statistics are still emerging, partly because many of the state programs simply are too new to generate outcomes, the law’s emphasis on getting people back to work has galvanized stakeholders to address the various challenges, and a consensus is emerging that it is not enough just to get people a job: To become productive citizens, TANF clients need help with all the difficult aspects of

their lives, particularly mental and addictive disorders. Furthermore, piecemeal efforts do not work. Moving from public assistance to paid employment must be integrated with treatment and the provision of support services, such as transportation and child care.

States that have adopted creative, holistic approaches and nonpunitive, substance-abuse screening methods are seeing positive results. Reports about interventions at the county, state, and national levels provide a snapshot of the evolving welfare reform terrain.

Oregon

Even before the passage of the 1996 law, Oregon had been pursuing its own welfare reform efforts for several years. Many of the lessons learned there are useful to other states.

In Oregon, a case manager coordinates each client’s employment skill training, job search, and treatment for substance abuse. Alcohol and drug abuse professionals are located in the welfare office, which “greatly facilitates the interface between the two systems and lets welfare offices stretch their limited case management resources,” according to a study of Oregon’s program, *Alcohol and Drug Treatment Into Welfare-to-Work Oriented Programs: Lessons From Oregon*, produced by Mathematica Policy Research, Inc., in Washington, DC.

Christa Sprinkle, M.A., is the coordinator of Mental Health and Alcohol and Drug Treatment Services for the Mt. Hood Community College Steps to Success Program, the prime contractor for welfare services in Oregon’s District 2. According to Ms. Sprinkle, District 2 tries to enroll all clients in an addiction awareness class as soon as possible.

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“It’s basically addiction 101—the nature of addiction and the fact that it’s a disease process,” she says. “This is usually followed by discussion about codependency and the effects of addiction on the family.”

Clients are tested for drugs “as needed,” says Ms. Sprinkle. “But this is only on the recommendation of the alcohol and drug clinician and authorization by the client’s case manager. It’s usually done when individuals are showing lots of signs that they are struggling with substance abuse but saying they have no problem with it.”

In Oregon, time in treatment counts as work for the purpose of receiving benefits. For clients who need treatment but fail to cooperate in obtaining it, Oregon has an elaborate system for sanctioning (reducing or discontinuing TANF benefits for varying lengths of time) to motivate clients.

Some drug treatment centers in Oregon are bringing employment staff on-site so that clients can learn job search skills while they are in treatment.

Oregon has also taken the lead in educating welfare staff about the nature of addiction.

“We are now doing a segment on fetal alcohol syndrome (FAS),” says Ms. Sprinkle. “Adult clients who were born with this syndrome are seen as obnoxious and scamming when they say, ‘yes, yes, I want to look for this job,’ and then when they come back and the case manager asks them if they did, they say, ‘I forgot.’”

FAS can have repercussions well into adulthood, and difficulty tracking multiple tasks is part of the syndrome, says Ms. Sprinkle. Understanding FAS enables the case manager to tailor the approach to the individuals’ needs. “You don’t assign them 20 things to do at once,” she explains. “You get [clients] to write down every step

of the one thing you are going to ask them to do for the next week.”

District 2 has a high rate of identification and placement of clients with substance abuse in treatment, says Ms. Sprinkle. During the course of 1 year, 762 individuals (15 percent of the TANF population in the county) were referred for an assessment, and 318 (42 percent of those referred) actually showed up. Of those, 260 needed ongoing treatment. (Many of the remaining 58 were referred for mental health-related therapy.) A total of 139 people (53 percent of those needing substance abuse treatment) completed it.

Ms. Sprinkle says her program keeps close track of individuals who are in recovery “so that [clients have] an expert who can support them and make sure there is a plan in place for transitions.”

By “transitions” Ms. Sprinkle is referring to the major changes that can occur in clients’ lives as they deal with substance abuse problems, learn new skills, and become employed.

“A lot of people will appear to sabotage themselves,” she explains. This is



Christa Sprinkle, MA. (l.), coordinator of Mental Health and Alcohol and Drug Treatment Services for Mt. Hood Community College’s Steps to Success Program, discusses referral procedures with alcohol and drug assessment specialist Sue Phelps.

natural, she says, because “there is a lot of stress for people on welfare getting work. There is a loss of a lifestyle, for as bleak as it may look, it’s theirs, they are familiar with it, and can cope with it. For women, their male partners may be incredibly threatened by the new skills they are learning.” In addition, there is the separation anxiety experienced by mothers and children when the mother starts to work.

Massachusetts

As in Oregon, the Massachusetts program, which was described at SAMHSA’s recent National Conference on Women, emphasizes providing employment assistance and substance abuse treatment in an integrated package.

In early 1999, Massachusetts inaugurated six pilot projects around the state, which furnish employment assistance and substance abuse treatment at one site, while providing for clients’ other needs, such as transportation and child care.

Cheryl Kennedy, M.S.W., assistant director of the Institute for Health and Recovery, explains that if a career center repeatedly refers to a job site people who fail because of their need for substance abuse treatment, the site will cease taking applicants from the center. “But if you have a system in place that can identify a substance abuse problem, you can provide support to the person, which will help the person keep the job,” she says.

Each of the pilots is designed to meet the needs of local clients. “Services might include afterhours child care or relapse prevention groups sponsored by the treatment provider,” says Ms. Kennedy. “They might include mothers’ groups because there are very specific issues of being a working mom in recovery.” One program is developing a Saturday morning



Richard Speigman, D.Crim (California Alameda County), and Marjorie Gutman, Ph.D. (Evaluator)

general equivalency degree class with child care provided.

In addition, Ms. Kennedy says, "We're providing technical assistance to instruct treatment providers about vocational training so [that] they can integrate vocational programming into treatment programs. We're also facilitating a lot of cross-educational presentations by the treatment providers to educate the vocational case workers about substance abuse, recovery, and relapse."

National Trends

A national demonstration program funded in part by SAMHSA, CASAWORKS for Families, is testing a hypothesis similar to the premise of the state programs described in Massachusetts and Oregon. That is, that the underlying problems of poverty, substance abuse, and domestic violence are heavily intertwined and therefore need to be tackled with an integrated, comprehensive package of services.

The CASAWORKS program was described at SAMHSA's National Conference on Women by Marjorie Gutman, Ph.D., who serves as the program's lead evaluator together with Thomas McLellan, Ph.D., and Robert Ketterlinus, Ph.D., at the

University of Pennsylvania's Treatment Research Institute.

CASAWORKS, funded by the Robert Wood Johnson Foundation, New York City, New York State, and CSAT, is a national program for the demonstration and evaluation of a new service model for women on TANF who abuse substances. Launched in summer 1998, the first phase of the program will last until 2001 and is devoted to pilot-testing and refining the CASAWORKS model of assistance in a variety of settings—both urban and rural—throughout the country. Eleven sites in nine states are participating in the program.

The model has at its core the components of employment, work readiness (including vocational and educational services), substance abuse treatment, and domestic violence as well as other components such as family and parenting services, mental and physical health services, and ancillary services, such as child care and transportation.

"There's always a lead organization at each location, usually a women's substance abuse treatment organization," says Dr. Gutman, "but there are usually formal arrangements with other partners to provide at least some of the other services. It's not like the old referral system most of us are used to, where a woman is told 'you need this' and then left to find it herself. It's more like a service network."

"The first phase of the evaluation is to determine the characteristics of women on TANF who abuse substances," Dr. Gutman says, emphasizing that the data so far are based on only 5 months of participant enrollment. The data were compared with data from another CSAT-funded program, the Target Cities Initiative, which dealt only with clients in selected large cities.

"Our preliminary conclusions are that the women in the CASAWORKS program

seemed to be less homogeneous in terms of demographic characteristics, less severe in their substance use/abuse, and more likely to have experienced victimization and legal problems," says Dr. Gutman.

The evaluation also will focus on the services the women receive and will examine whether CASAWORKS has been effective in removing barriers and helping women transition to work. Results should be available by the end of the year 2000.

Alameda County

Dr. Speigman, quoted earlier, recently conducted a study, the Alameda County CalWORKs Needs Assessment, funded by the California Department of Alcohol and Drug Programs, the County of Alameda, and CSAT. The study was initiated to determine the needs of new and transitioning recipients of public assistance, identify the barriers to self-sufficiency and successful departure from CalWORKs, and determine the outcomes of the participants in the program. CalWORKs is California's version of TANE.

Interviews were conducted with a cross-section of 512 adults who received cash assistance from the Alameda County CalWORKs program and were not exempt from the work requirement. One in twenty self-reported a current need for help with alcohol or drug problems, and virtually all reported that they did receive help. However, one in six recipients of CalWORKs benefits self-reported a need for help with emotional or mental problems; yet almost half of them failed to receive the help they needed. In addition, approximately one in eight participants reported experiencing trouble with mental or emotional problems in the past year, and more than half of this group said that

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Welfare Reform

Personal Perspectives

The potential positive and negative consequences of the 1996 Personal Responsibility and Work Opportunity Reconciliation Act have generated much public discussion, especially in light of rapidly falling caseloads. In August 1999, the Federal Government reported that the national caseload for people receiving Temporary Assistance to Needy Families (TANF) had declined by more than one-third (40 percent fewer recipients). Little is known, however, about the fate of families that have left welfare, particularly their economic status and the well-being of their children. Likewise, the effects of welfare reform on people with mental and addictive disorders remain unclear.

To fill that information gap, SAMHSA funded a "Welfare Reform Community Case Studies" project, conducted by the Legal Action Center and the National Coalition of State Alcohol and Drug Treatment and Prevention Associations. The project held

12 focus groups (structured discussions) in 6 communities throughout the United States between November 1998 and May 1999 to collect information about the effects of welfare reform on both providers and consumers of publicly funded treatment services for alcohol and drug abuse.

A preliminary background paper based on the focus groups provides an illuminating glimpse into the experience of consumers of services at a grassroots level. Information was gathered in seven topic areas.

Knowledge, Attitudes, and Beliefs

"My [welfare] case worker had asked me [about my addiction]. First, I lied to her, and then it got too bad. I had to tell the truth, and she . . . g[o]t [me] in this program She stayed on me I tried about three times to stop

going to [treatment], and she was calling me. I was saying, what is wrong with this lady; why is she calling me . . . ? I care about you [was her response]."

"Some treat you . . . like dirt You're an addict, and you just screwed up. [S]ome . . . seem like they care and they want you to get some help, and some are just . . . doing their job."

Eligibility Issues

"I went down there and applied [for benefits] [T]o this day, I still don't know who my baby's father is because of my addiction. They denied me. They simply said, 'We can't help you if you can't tell us the name. You don't get a check.' [I]n my case, I was a prostitute on the streets. I was raped [The answer still was], 'Well, if you can't tell us the father's name, you're not getting . . . help.'"

"[W]hen I first answered that question [about whether I had a felony drug conviction], . . . that was everything. It wiped me out [F]rom then on after I did that, I never answered it. I'd check 'no' They make you want to lie to where you're not going to get cut off the following month."

"Thank God all my convictions were before [19]96, or I wouldn't be able to get TANF for my children, . . . even [with] m[y] being in treatment, getting my life back together There are some women out there struggling, . . . [but] they can't see [any] way out because there is no way out because of your past."

Treatment Issues

"What motivates me to be in treatment is my 13-year-old son My 13-year-old is looking at me like it's okay for him to start smoking pot, and I do not want him to go there."

"[B]eing an addict, I really didn't have control over [m]y using, but I didn't want to use with this baby."

Sanctions and Time Limits

"[I]f they push you out there to get a job [and say they're] going to sanction you if you don't get that 25 hours a week, . . . instead of getting \$300 you get \$150. Then it clicks in, well, I need money. Then you start working."

"[C]utting you off doesn't keep you motivated [Y]ou are trying to do the right thing, then all of a sudden bad things start falling on you. And it makes you want to give up. It doesn't really give you any motivation . . . [except] to go [back to] using drugs."

Perceived Barriers, Needs, and Resources

"A lot of us don't have transportation, . . . but that really needs to be taken into account, all the different travel time."

"[B]ecause I don't have a job yet and I'm looking for one, I don't have the funds always to take the bus [That] could be improved by providing some kind of . . . tokens or . . . bus passes for people [who] are looking for jobs."

Effects on Children

"I was going to treatment 5 days a week from 9:00 to 5:00 and had to work from 5:00 to 11:00. So I had no time with my kids"

"In my struggles trying to go to . . . outpatient [treatment], my benefits have been cut and sanctioned numerous times, and the children . . . really suffer. Because I couldn't pay my rent, my rent would get behind. And we just didn't . . . have toilet paper, . . . and we were stuck. The kids really suffered from that."

Work and "Work-First" Requirements

"This program requires me to go back to school and work part time. And I have no vehicle even. So I'm very frightened. I'm doing all this work, my outpatient [treatment], [and] my meetings."

"[W]hen I . . . got my job, I was so proud It is an awesome feeling working, and it's your money. You earned it. And nobody can take that." ▸



Parental Drug Abuse in Child Welfare Cases

Tackling Dilemmas



In April of this year, the U.S. Department of Health and Human Services published a report, *Blending Perspectives and Building Common Ground: A Report to Congress on Substance Abuse and Child Protection*. The purpose was to inform Congress about the problem of parental substance abuse in child welfare cases and to make recommendations for improving services. The report was a joint effort by three components of the U.S. Department of Health and Human Services: the Children's Bureau, Administration for Children and Families; Office of the Assistant Secretary for Planning and Evaluation; and SAMHSA. Administration for Children and Families Commissioner Patricia Montoya, M.P.A., presented highlights at SAMHSA's Second National Conference on Women.

Within the child welfare system, where difficult decisions are made every day, child welfare workers face particularly complex dilemmas when working with families whose multiple problems include both substance abuse and child maltreatment.

"Part of what makes this problem so complicated is the fact that substance abuse treatment for parents is often a lengthy process that includes periods of relapse, which does not fit well with the

physical, emotional, and developmental needs of children who cannot wait for safety and permanency," Ms. Montoya said. "Moreover, it is difficult for child welfare workers to determine what level of functional impairment will enable a parent with substance abuse problems to retain or resume his or her parental role without jeopardizing a child's safety."

The Adoption and Safe Families Act, passed in 1997, has brought even more urgency to this issue. The Federal law requires a permanent placement plan after 12 months for children in the child welfare system. It further requires the child welfare agency to file a request with a family court judge for termination of parental rights if the child has been in out-of-home care for 15 of the previous 22 months. The law is intended to accelerate the process of adoption to provide children with a more stable and consistent living environment.

The report notes that 11 percent of children in the United States (approximately 8.3 million) live with at least one parent who abuses alcohol or illicit drugs. Parents who have substance abuse problems are demographically quite similar to the United States population as a whole. They are as likely to be fathers as mothers, although mothers with substance abuse problems are much more likely than fathers to be reported to child protective services.

Parental substance abuse is a contributing factor in one-third to two-

thirds of the cases within the child welfare system, according to the report. Children in the welfare system whose parents have substance abuse problems are generally younger than those whose parents do not.

They are also more likely to be the victims of severe and chronic neglect, come from families with more problems overall, and be placed in foster care rather than served while remaining at home. Once in foster care, children whose parents have substance abuse problems tend to remain there for longer periods than other children.

Children of substance-abusing parents have poorer physical, intellectual, social, and emotional development than other children. According to the report, prenatal abuse of alcohol appears to have more severe and long-lasting effects on

development, with serious intellectual and behavioral consequences in many children, than does abuse of cocaine and other illicit drugs. However, the report adds, research shows that factors in the postnatal environment can ameliorate prenatal substance abuse in predicting developmental outcomes.

Children of substance-abusing parents are also at risk for substance abuse themselves.

Although both the substance abuse treatment and child welfare systems have as their goal a healthy, functional family, different perspectives and philosophies



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Family Drug Treatment Courts Offer New Option



Think substance abuse only affects the person using drugs? Think again. According to a recent report, substance abuse played a major role in a third of the Nation's nearly 1 million child abuse and neglect cases and up to two-thirds of foster care cases in 1997. *Blending Perspectives and Building Common Ground: A Report to Congress on Substance Abuse and Child Protection*, published in April by the U.S. Department of Health and Human Services, urges closer collaboration between the child protection and substance abuse treatment systems. (See *SAMHSA News*, p. 18.)

"In families where there is child abuse and neglect, there are often multiple problems that require comprehensive solutions," says SAMHSA Administrator Nelba R. Chavez, Ph.D. "Our experience and research have shown that integrating substance abuse and mental health services into social and health programs is critical in meeting the needs of parents and children."

In response to the growing need for services addressing both parental substance abuse and child welfare, SAMHSA's Center for Substance Abuse

Treatment (CSAT) is sponsoring a pilot project that uses an innovative new approach called "family drug treatment courts." The approach is designed to handle child abuse and neglect cases of parents who are substance abusers. It combines legal processing, treatment for alcohol- and drug-abusing parents, and support services for children and their families. Clients are mostly substance-abusing women with children. The project's ultimate goal is to improve the chances of keeping families together.

The CSAT project also responds to the Adoption and Safe Families Act, passed in 1997. The Federal law requires a permanent placement plan after 12 months for children in the child welfare system. It further requires the child welfare agency to file a request with a family court judge for termination of parental rights if the child has been in out-of-home care for 15 of the previous 22 months. The law is intended to accelerate the process of adoption to provide children with a more stable and consistent living environment.

Because the concept of the family drug treatment court is so new, very few of these courts exist within the United States. Launched in 1997, the CSAT project is supporting pilot sites in the Manhattan Family Court, New York, NY, the Miami-Dade County Juvenile Court, Miami, FL, and the Jackson County, MO, Family Court. Satellite courts in San Diego, CA, Suffolk County, NY, and Franklin County, MA, are receiving training.

As part of this effort, CSAT is also conducting a feasibility study to explore whether the pilot project

should be expanded and evaluated more comprehensively.

"The waves of substance abuse that have swept over the Nation during the past 20 years have transformed—even created a sense of crisis in—the juvenile and family courts as they attempt to cope with a new client population and expanding caseloads. Child protection agencies are even more overburdened," says Nicholas L. Demos, J.D., Chief of CSAT's System Development and Integration Branch, which oversees the project. "If parents' substance abuse isn't dealt with, children stay in foster care longer than necessary. The trauma that these children undergo can arrest their development and put them at risk for substance abuse or for repeating the cycle of neglect and abuse with their own children later in life."

The family drug treatment court project's efforts to break that intergenerational cycle are especially timely, adds Mr. Demos, noting that welfare reform is intensifying the pressure on single mothers to become financially self-sufficient quickly.

Reuniting Families

Family drug treatment courts have their roots in adult drug courts, an idea first put into practice in 1989 in response to the crack cocaine epidemic. Adult drug courts allow certain drug offenders to choose substance abuse treatment rather than prison sentences. The decreased drug use and recidivism that resulted helped convince judges to try a similar approach to abuse and neglect cases in the

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mid-1990s. For adults in family drug treatment courts, however, the stakes are even higher: If they fail to become drug-free within the allotted time period, they may lose their children.

According to the American Bar Association, about 20 jurisdictions in 10 states either have family drug treatment courts or are planning to institute them. Although details vary, family drug treatment courts typically feature the following characteristics:

- A goal of reunifying families in safe, healthy environments
- A nonadversarial approach with close client/judge relationships
- Interdisciplinary collaboration led by a judge
- Early identification and eligibility screening
- A continuum of alcohol and drug treatment services
- Rehabilitative and logistical services, such as parenting classes, employment counseling, and housing assistance, to support families during the recovery process
- Close monitoring of participants, including alcohol and drug testing
- A system of rewards, such as more frequent visits with children or dismissal of criminal charges, and sanctions, such as stepped-up treatment or more frequent urinalysis, administered during frequent court hearings
- Aftercare services designed to reduce the chances of relapse.

“The family drug treatment court movement forces the system to be responsible and deliver services where they hadn’t necessarily been delivered before,” says CSAT project officer Bruce Fry, J.D., M.P.P., adding that there is plenty of

evidence to suggest that coerced treatment works. “The hope is that more people will now end up being treated and that more families will be reunited than under the old system.”

Case in Point

Take Jackson County’s family drug treatment court in Kansas City, MO, for example. Convinced that traditional courts’ adversarial approach only reinforced offenders’ denial of their substance abuse problems, the county launched its family drug treatment court in 1998.

“In traditional family court, the court would give a family a list of things they were supposed to do and ask them to come back in 6 months to review whether or not they accomplished those things,” says Commissioner Molly Merrigan, J.D., who leads the family drug treatment court program. “Usually what would happen was that those issues wouldn’t get resolved. Because of their addictions, most people just don’t have the ability to follow through without extensive intervention and hand-holding.”



Commissioner Molly Merrigan, J.D.

The family drug treatment court provides that kind of support. Focusing on women who have given birth to drug-exposed infants, the process begins with routine testing of mothers and infants following childbirth. If either the mother or child tests positive for illicit drugs, social workers conduct a thorough assessment, including a visit to the family’s home. Abuse or neglect charges may be filed at this point.

Within 24 hours, the judge decides whether it is safe to send the child home or whether the child should go to foster care. Unlike the CSAT pilot programs in Manhattan and Miami, which automatically remove children from the home and assist parents to regain them through substance abuse recovery, the Kansas City program keeps families together if it is safe to do so.

Three to seven days after a baby’s birth, the judge sees the mother in court. Although the mother is often already receiving substance abuse treatment, this first court date allows the judge to assess what other needs the mother has. Working with case managers, the mother then receives an individualized roster of additional services ranging from therapy, medical care, and health education to transportation and child care to parenting programs, domestic violence education, and treatment for the long-term effects of childhood sexual and other physical abuse. Frequent court dates and urinalysis allow the judge to monitor progress closely and administer sanctions and rewards as appropriate.

Does this kind of intensive intervention work? The signs look good so far, says Mary R. Haack, Ph.D., R.N., the project’s principal investigator. Dr. Haack is an associate professor of nursing at the Rutgers College of Nursing and an associate professor of health services management and policy at George Washington University’s Center for Health Services Research and Policy.

According to Dr. Haack, the evaluation includes clinical measures, record reviews, and interviews with court and treatment personnel. Seventy-one percent of Kansas City's family drug treatment court participants have successfully completed treatment so far. Seventy-six percent of the women were drug-free by the time they were discharged, with the remainder's status unknown. Although only one woman had a job when she was admitted, 71 percent were working either part time or full time by the time they completed the program.

Two factors may help explain these excellent results, according to Dr. Haack. She suspects that the unusually high completion rate, for example, is connected to the fact that the Kansas City program allows mothers to bring their children with them to treatment.

And the dramatic drop in drug use may be related to the program's holistic emphasis on treating underlying problems. Half the participants had suffered serious depression at some point in their lives; almost half had experienced emotional or physical abuse. Nineteen percent were having problems with homelessness when they were admitted to the program. Eighteen percent alleged domestic violence.

Commissioner Merrigan does not need to wait for the final data to come in to be convinced that the program is working. She points to one of her clients as an example. A cocaine user for 13 years, Sally* finally had an awakening of sorts when her third child tested positive for cocaine at birth. "That's when I hit bottom and knew I definitely had a problem," explains Sally, now a 40-year-old single mother.

Closely monitored by Commissioner Merrigan, Sally underwent outpatient substance abuse treatment, found an apartment, and started working two jobs. The project showered Sally with certificates and other rewards for staying drug-free. It provided a case manager who escorted her to court dates and doctors' appointments. It even helped pay her rent for a few months.

"I knew I had a choice: pulling myself together or losing my children. The drug treatment court gives you a chance to get on your feet again," says Sally. "They want you to succeed." ▸

—*By Rebecca A. Clay*

* A pseudonym.

"Tackling Dilemmas" continued from page 18

sometimes impede cooperation, according to the report. Several key differences underlie the most common misunderstandings. These include different definitions of who is the "client," what outcomes are expected on what timelines, and different responses to setbacks.

In addition, differences between state and Federal laws, the sense of crisis underlying decisions regarding children in the welfare system, chronic shortages of substance abuse treatment services (especially those appropriate for women with young children), and confidentiality requirements may all complicate collaboration, the report says.

The report highlights several ways to improve services, including emphasizing prevention to reduce the risk of maltreated children becoming the next generation of addicted, abusive, or neglectful parents; improving the skills of service providers in both fields in identifying problems; and increasing the availability of services for substance abuse treatment.

The report also outlines some specific efforts by agencies within the U.S. Department of Health and Human Services aimed at addressing these issues.

To obtain a copy of *Blending Perspectives and Building Common Ground: A Report to Congress on Substance Abuse and Child Protection*, contact the National Clearinghouse on Child Abuse and Neglect Information, 330 C Street, S.W., Washington, DC 20447. Telephone: 1 (800) FYI-3366. The report may be requested by e-mail at nccanch@calib.com and can be accessed electronically through either of the following Web sites: www.aspe.os.dhhs.gov or www.acf.dhhs.gov/programs/cb/. ▸



Concurrent Clocks Set Multiple Agendas for Women

At the Second National Conference on Women, Nancy Young, Ph.D., director of Children and Family Futures, Inc., in Irvine, CA, offered a novel analogy of concurrent clocks for understanding the interplay of the issues of welfare reform, child welfare, and substance abuse.

The first clock, she said, is TANF (Temporary Assistance for Needy Families, the program that replaced welfare), which stipulates that recipients of public assistance must have a job within 24 months and establishes a lifetime limit of 60 months for receiving benefits.

The second is the ASFA (Adoption and Safe Families Act), which requires a permanent plan for children after 12 months and requires the filing of a request

in family court to terminate parental rights if the child has been in out-of-home care for 15 of the previous 22 months.

Then there is the Substance Abuse Recovery clock, which regards recovery as a lifetime process, taking 1 day at a time.

Finally, there is the Child Development clock, which is ongoing and especially critical during the first 3 years of life.

All these clocks are running simultaneously but not synchronously, Dr. Young explained, so welfare and child welfare agencies must collaborate as closely as possible to achieve the best results for clients.

She added, "I would propose that we begin to monitor a fifth clock: the length



Dr. Nancy Young

of time that it takes for action at the Federal, state, and community levels How are we going to hold our policy leaders accountable for action and a timetable that is commensurate with [the] timetable we have placed on the families we seek to serve? . . . It will take leadership with a real sense of urgency to make a difference in [the] lives of these families." ▶



First Lady Addresses Women's Conference



First Lady Hillary Rodham Clinton addressed participants at SAMHSA's Second National Conference on Women by videotape. Greeting participants, she said, "As I've been privileged to travel around the world, I [have] seen firsthand how many health challenges are common to women everywhere. And sadly, I've seen how often these problems do not receive the attention or the resources they deserve." She urged women to speak up, "not only for ourselves but for the women who cannot be here, the women often rendered voiceless, too often left behind. We could imagine a day when all Americans have access to quality, affordable health care regardless of the color of their skin, the amount of money in their pockets, or whether they're boys or girls. And when that day comes, it will be because you came together today with a vision for women's health in the 21st century, and [it] will be because you went home tomorrow with a commitment to making that vision real in the lives of women and their families all over this country and [the] world. Thank you very much for your commitment." ▶

Women in the 21st Century

A Multicultural View



From l. to r.: Back row, Cheyenne Bell, J.D.; Antonia C. Novello, M.D.; Nelba R. Chavez, Ph.D.; Janice Mirikitani. Front, Cinda Hughes

"You've heard the expression 'She's all that!' I think to meet the challenges of the 21st century we have to be all that! I want to call ourselves out—and be all that: generate our power; heal our wounds; celebrate our brilliance, boldness, all our beautiful colors, as we build on the strengths of women!"

Janice Mirikitani, executive director of Glide Memorial Church in San Francisco, CA, sounded this call to conference participants in the opening plenary of the Second National Conference on Women, "A Multicultural Look at Women in the 21st Century."

The plenary featured diverse perspectives of women from different racial and ethnic backgrounds on the experience of being female within a significant cultural group. In attempting to explain the past and account for the present, each woman articulated a vision of the future that

encompassed both her own culture and the larger community of American women as a whole.

In her capacity as executive director at Glide, Ms. Mirikitani oversees 50 programs, a staff of 200, and a budget of \$10 million. In addition, she is a published writer and poet.

Yet, she said, "Growing up in a society of predominantly white images, I internalized my absence of diversity. Nothing was worse than being me, being yellow, with not fine hair, not blond hair, called Jap and slant-eyed girl. So I bleached my skin; Scotch-taped my eyes; created breasts by Wonderbra; permed, ratted, and dyed my hair orange."

But, she stressed, breaking out of this "martyrdom, the secrets, and self-pity" was essential to building her own inner strength. "I hated to give up that cross,

that empty room, that victim, that cage that had become so comfortable," she said. "I had to call myself out of those walls of denial, from the rivers of self-pity. I had to forgive myself and begin to find myself acceptable."

Urging women to "invent ourselves anew," she concluded, "Remove the thief who stole the precious treasure of our belief in our beauty and worth; give birth to words that call us out and make us shout our righteous names, that make this claim to restore, revive our lives, not just survive, but thrive. Make us alive . . . alive. Yes, because we are all that!"

The next speaker, Stephanie Covington, Ph.D., psychologist and coauthor of the book *Leaving the Enchanted Forest: The Path From Relationship Addiction to Intimacy*, framed her remarks within the context of the approaching millennium, which, she said, has "provided a real clatter of both alarm and anticipation . . .

"What's regrettable," she said, is that "it takes attention away from what I think we could be looking at. This year 2000 is like a collective birthday. And big birthdays are really times for reflection . . . If we really look back over the sweep of the [p]ast 10 centuries, . . . the change in the status of women has actually been the most remarkable thing. So, as women moving into this next millennium, we're in a time of transition.

"When I think transition," she said, "I think of monkey bars . . . Remember growing up and swinging on those bars? We had to let go of the bar behind us as we reached out for the bar before us. There

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was actually a split moment in time when we were holding onto nothing. That's transition," she said. "That's the time we're living in now. We're letting go of what's behind us, we're reaching out for what's in front of us, and often we feel like there's nothing to hold onto. And I believe our main problem is that we have forgotten the face of our childhood, when we were children on those monkey bars and we had a vision ahead of us and we were in right motion and we kept moving. There was a force in the universe that held us up even though we were holding on to nothing. And we need to go back and remember that . . . We need a vision to carry us forward."

Former U.S. Surgeon General Antonia Novello, M.D., M.P.H., opened her remarks by saying, "Buenos Dias!," and when the audience did not reply as loudly as she'd hoped, she urged, "I can't hear you. This is Los Angeles. Buenos Dias!"

Telling her audience that she had learned much during her years as Surgeon General, Dr. Novello said, "More than anything, I learned that when you get to the top of the promised land, you don't forget your race, your language, or your community."

She reminded the audience that "by the year 2050, 25 percent of all people in this country will be Hispanic, whether America wants it, cares, or needs it." She told listeners that "the first thing we have to do is stop this stereotype against women and minorities, because we stand for the things that America stands for. We stand for family, we stand for heritage, we stand for children, and we stand for love of God. We do not weaken the American family; we strengthen it."

San Francisco lawyer Cheyenne Bell, J.D., brought to the panel her expertise as director of community programs at the San Francisco Juvenile Probation Department. In this capacity, she is in charge of



Stephanie S. Covington, Ph.D.

administering \$3 million for community-based programs for at-risk youth or youth on probation.

"There are 519 million black women on the planet Earth, and they are represented in all 7 continents of the world. In almost every country, you can find black women," she said. "We travel with a force that is greater than ourselves.

"But at the same time . . . in 1999, moving into the millennium causes me some great concern . . .," she continued. "We need to get a lot more serious about issues of mental health. In particular, I say this in terms of communities of color because we have a tradition—I'm not going to even call it a tradition—but really a practice of trying to avoid the issue of mental health illnesses. And they exist, and they're real. And we project this stuff onto our children, unknowingly sometimes: We didn't create children to become murderers; we didn't birth children to become victims of substance abuse, to become heroin addicts and cocaine addicts

"We have to . . . begin to deal with all of the things that have happened to them

since they were born [that] have not been properly addressed," she said.

The final speaker, Cinda Hughes, spoke from the perspective of a Native American member of the Kiowa tribe. She is currently employed by the research and policy analysis division of the Oklahoma State Senate. In addition, she produces and hosts a nationally syndicated, weekly Native American radio program that focuses on current political and social issues.

"Who is today's Native American woman?" she asked. "Where will she be in her journey 100 years from now? She is the first and least-known American woman. Far from the submissive, downtrodden 'squaw' or the regal Pocahontas of popular myth, the Native American woman emerges as a proud, sometimes stoic, always human individual from whom those who came after can learn much.

"During the last century," she added, "the vanquished tribes of America were confined to desolate reservations with their daily regimen of hardships, humiliation, and exploitation We essentially became wards of the Government However, life changed much more slowly for Native American women than for their male counterparts. Even on a reservation there were still children to be raised, meals to be cooked, and housework to be done. With strength and resolve, many of our women held, and continue to hold, their families together through some very dark times.

"It is imperative for Native women to reclaim cultural traditions in order to stop the negative cycles created by social ills such as alcoholism and domestic abuse The mores of our past beckon us back to a time when family was basically healthy and intact. There are ways to reconcile the present with the past." ▀

Youth Contribute Vitality



Panel moderator Beverly Thomas

“We know that many of the women in the audience are leaders in our community, . . . and we would like to know how to prepare for your positions!” This is how middle school student Michelle Reid, of the Second National Conference on Women youth track, framed the teens’ request for the creation of a mentoring program by the adult participants. It is but one small illustration of the vitality, enthusiasm, and frankness that youth track participants brought to the proceedings.

By inviting adolescents to participate in the National Conference on Women for the first time, conference planners hoped that the perspective of the young women would help shape the issues, goals, and strategies that would be their legacy in the next century.

“I don’t want you to be modest. I don’t want you to be shy. We are interested

in the things you see that we need to know about,” said SAMHSA Administrator Nelba R. Chavez, Ph.D., in greeting the young participants. The teenagers took her at her word and spoke up with a dynamism that surprised—and energized—everyone present.

Approximately 25 young women ages 11 to 18 were nominated by SAMHSA and other Federal cosponsors of the conference. They represented a geographic, racial, and ethnic mix of young women throughout the United States.

Much of their effort was devoted to a separate series of discussion groups (closed to adults) in which they dealt with the topics of intergenerational issues, relationships between partners, self-esteem, health issues, physical health care, foster care/transition from foster care, and mixed messages from the media.

In addition, five workshops in the main conference track were devoted to presentations by the adolescents themselves on topics including mental health, substance abuse prevention, substance abuse treatment, HIV/AIDS, and school violence.

Youth track participants presented a set of recommendations to all attendees on the final day of the conference. Following are selected recommendations from this panel, fleshed out by descriptions from some of the youth track presentations.

Panel moderator Beverly Thomas also elaborated on some of the recommendations for *SAMHSA News* at the

end of the conference. Ms. Thomas, 19, is employed by PROTOTYPES, a Los Angeles program for women with mental and addictive disorders, who have also suffered physical or sexual abuse, and their children. Ms. Thomas works as a youth outreach worker in the Women and AIDS Risk Network and attended the conference as a youth track facilitator.

Youth Track Recommendations by Topic

Women’s Health Issues

Youth track recommendations on women’s health issues were presented by Sharae Sanchez of Boston, MA. Among the recommendations was a request for youth peer counselors at clinics and hospitals.

“We want to feel comfortable when we walk in the door and see young teenagers who are willing to help everyone just [the same] as adults,” Ms. Sanchez said.

Ms. Thomas explained, “Youth [are] more receptive to someone that looks like them, speaks like them, . . . can relate to them.” She gave the following example from her own work: “AIDS is a scary topic. You can’t go direct, because no one wants to talk about it. You have to ease up to it.”

In her own work, Ms. Thomas said, “I try to spark conversation . . . walk around and just ask a couple of questions . . . get them, whoever would, to talk to me . . . Just build a comfortable environment

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for youth, and discuss different issues that they may have”

In addition, Ms. Sanchez reported a need to have “people work with the judicial system to lock down on older men who get teenage females pregnant. They need to take responsibility for their children, and maybe . . . basically, they need to be there for that child and that teenage mother, if possible.”

Women’s Physical Health Care

Angie Morales, also from Boston, MA, presented the group’s recommendations on women’s physical health care. Among the most pressing issues the group stressed is a great need to make quality health care available for 18-year-old adolescents who are no longer covered by their parents’ insurance or through public assistance. The group also recommended that transitional health care coverage be available for young adults between ages 18 and 21.

Ms. Thomas described her personal encounter with this very difficult issue. “I’ve experienced being cut off . . . , and that is very scary. See, what happened to me is [when I turned 18], my family doctor turned me down. And the way I found out, I went to the doctor for a visit, and they told me, ‘We can’t do anything for you because your coverage does not exist.’ This affects a lot of people. For 18-year-olds on up, till they find a job, they get no health insurance. So thank God I have a job with some benefits.”

Foster Care/Transition From Foster Care

Badriyyah Al-Islam, of Greenville, SC, presented the group’s recommendations

concerning foster care. “First of all,” she said, “I’d like to talk about some of the feelings and emotions that come from a child being in foster care and trying to make that transition. They’ll feel depressed, reckless, alone, and stressed out. They may feel unloved and humiliated because they . . . feel abandoned and unsupported by friends and family and everyone else in society.”

To counter these problems, Ms. Al-Islam told conference participants that the group recommended the creation of vocational programs so that before adolescents reached the age when their benefits would be terminated, those in foster care would have acquired skills, “so they won’t just be dropped off in the middle of the ocean. They can have something to float with.”

Ms. Al-Islam also recommended the establishment of consistent mentoring relationships and community-based kinship programs as well as assistance with resource programs. “So when they send you that letter, when you turn 18 or 19 years old, saying, ‘I’m sorry, Ms. Jones, you are no longer eligible for our services,’ on the back of that letter is a list of phone numbers saying where you can get help,” Ms. Al-Islam explained.

Relationships Between Partners

Cara Bobus, of Santa Rosa, CA, presented the recommendations in this area. Perhaps the most pointed was “We



Michelle Reid

need to see more positive relationship role models,” she said.

She also highlighted the problem of stalking by boyfriends and girlfriends, urging more education about stalking, violence, and restraining orders.

Ms. Thomas elaborated: “If the girl is going with an older guy, that’s where it usually happens, because when you’re going with an older guy, the guy will try, well, he really controls the relationship. So say the young girl is ready to break up with him, and he just is . . . not ready to let her go, so he’ll still call, come around, and stalk her, and she won’t know what to do.”

Intergenerational Issues

Aisha Campbell, of Portland, OR, recommended that “we explore the differences that have come about in the growth of our society and the complex and tremendous impact these changes . . . will continue to have on the thinking and behaviors of each generation.”

Susana Valdez, of Los Angeles, CA, spoke about her experience as a recipient of services from PROTOTYPES, saying, “They advise me. They don’t tell me what to do, but they give me suggestions . . . so that I can feel comfortable . . . ; they’re not mothering me, but they’re . . . being my friend.”

Mixed Messages From the Media

Ngozi Olemgbe, of Portland, OR, said, “Mass media is any form of communication that is created by a few

and is seen by many. It's not just radio and TV. It's shopping malls across the country telling us the standard of what we should all have. And they are controlled by rich, older, white men, which is a minority in this country, and they're telling us how we should live

"As a solution," said Ms. Olemgbe, "we must practice media literacy: Analyze and watch the subliminal, misrepresented messages targeting youth and women; change negative images of women and youth . . . ; and stop buying these products because that's what their point is. They want us to buy those products so [that] they can make money. If we stop buying it, then they don't survive."

Self-Esteem

"Don't assume things about young people because you don't know me," said Michelle Reid, of Atlanta, GA. Instead, she said, "accept people as who they are."



Margaret Campbell

Ms. Thomas spoke of self-worth as a characteristic that has helped her persevere: "Once I realize how much I'm really worth, how important I am, it depends on the way you value yourself. You can hear something over and over and over: 'Don't have unprotected sex. You will catch STDs; you'll get AIDS.' But that's beside the point. If you value yourself, you don't even want to take the risk."

Margaret Campbell, of Boston, MA, concluded the panel presentation by saying, "I want to say to the elders in the audience that I've heard a lot of talk . . . about us being the future. Yes, we know that. But . . . we—as a Nation of young women, adolescent girls, and little girls coming up—we cannot be the future if we do not know how to maneuver through the present. We need your assistance in that." ▶

"Welfare to Work" continued from page 15

the problem interfered with work or training activities.

These rates are likely minimums, Dr. Speigman says, reflecting the subjective nature of self-reported experiences and the possible reluctance of study participants to reveal these problems during an interview.

"The findings suggest that mental health problems far outweigh alcohol and drug issues for the welfare population," Dr. Speigman says. "There has been much conjecture about substance abuse and mental health problems as barriers to successful departure from welfare. Welfare planners may need to consider the impact of mental problems on the client's ability to work and the implications for 'work-first' welfare policies as well as the availability of mental health services in the community to meet the need."

By supporting and analyzing the progress of county, state, and national welfare reform efforts, SAMHSA seeks to help people achieve a sense of autonomy and self-sufficiency that comes not only from paid employment but also from a drug-free, mentally healthy lifestyle.

"Welfare reform can serve as an opportunity to identify, assess, and treat families affected by substance abuse and mental health problems who may have been overlooked or ignored in the entitlement program," says Ulonda B. Shamwell, M.S.W., SAMHSA Associate Administrator for Women's Services.

SAMHSA Administrator Nelba R. Chavez, Ph.D., adds, "Our goal is not simply to reduce the number of people receiving public assistance. Our goal is to make a real difference in people's lives." ▶

—By David Holzman

I n T h e i r



Kathie Prieto

Aisha Campbell

Mentor to Mentor

Forging a bond between an adult and a teenager is a formidable feat. Here is how one such bond was formed and what it has meant to two conference participants from a program funded by SAMHSA's Center for Substance Abuse Prevention. Aisha Campbell (r.), now age 17, came 5 years ago to DaDa Kidogo (the Swahili word for "little sister"), a substance abuse prevention program run by Kathie L. Prieto, L.C.S.W. (l.), at Project Network in Portland, OR.

Aisha Campbell: I wasn't actually supposed to be part of the group. I was in eighth grade, and one day after school, all my friends, I noticed, they were all . . . going to this one room, and they looked like they were going to have like, a party or something. I wondered why I wasn't on the list to go. So I went in—actually myself and my best friend—and asked them what they were doing there. They told us that it was a program for . . . prevention or something like that. I guess they didn't

label us as at-risk, or as at-risk as the others they chose. We really didn't know much about it, but it was like, well, you guys are here having fun, and we didn't get invited. Kathie Prieto said that she couldn't turn us away.

Kathie Prieto: Initially, Aisha wasn't targeted to come into our program. She and two or three other girls came up to us and said, "Why didn't you choose us to be in your program?" They all came together in kind of a confrontational style. They're urban girls, and they've grown up in tough neighborhoods.

I'm not exactly sure what was her motivation. But we wanted to identify the leaders in the school, girls that demonstrated leadership qualities, be they negative or positive, because the negative has just as much influence as the positive. And I could tell that Aisha was a leader. She has a lot of leadership capabilities and has had to overcome many obstacles herself.

Aisha Campbell: At DaDa Kidogo, we've gone on retreats, like a camping trip for the weekend, [and] field trips [and have gotten] help with homework. We got in . . . in the eighth grade, and we [have] moved on to being big sisters now. We were mentored, and now we are actually mentors or big sisters. I got a full scholarship to the University of Portland, where I'll be doing pre-med studies. I'm not really sure exactly what I want to be, but I know I want to do something in the medical field because I enjoy helping others . . .

.....
"...the key thing in these programs is the ability of staff to form attachments and build relationships with these girls."
.....

Kathie Prieto: I think the key thing in these programs is the ability of staff to form attachments and build relationships with these girls. It's very difficult initially. I had to use a lot of my own upbringing in inner-city Los Angeles to be able to relate to them. You have to be able to relate in a way that is genuine because the kids will see right through you. And they help each other navigate through the system by sharing the hope that they're going to get through this. ▸

Own Words

Mothers and Daughters



(l. to r.) Jessica Bobus, Cara Bobus, Linda Myers

For conference participants Linda Myers (r.) and her daughters Cara (c.) and Jessica (l.) Bobus, recovery has been a

family endeavor. Mrs. Myers said, "I came into recovery wanting it for me and knowing I couldn't deal with five children—at first. I had to fix me, and then I was able to take them back one at a time."

Cara Bobus told participants that she had come to realize that, "if I put myself together, the world around me will become easier to live in . . . I'm also trying in every way possible to

continue to get help and support from others because I know I can't do it alone."

Jessica Bobus emphasized how much the special school she attends has been useful to her. "I haven't heard of any other school like it . . . I think they should make a lot more like it . . . because everyone there is close like a family."

Mrs. Myers added, "If I was to give a message, it would be: As an adult or as a parent, don't judge yourself because your children have disabilities. Cara has a disability. It's an emotional disability. My father had it, my brother had it, my son [had it]. Why wouldn't she have it? The gift is finding a solution." ▶

Don't Pity Me . . .



Angelica Lopez, of Oakland, CA, questioned Federal officials at a town meeting held at SAMHSA's Second National Conference on Women. Ms. Lopez is a participant in the Living Out Loud program run by Progressive Research and Training for Action in Oakland, CA, and funded in part by SAMHSA's Center for Substance Abuse Prevention. The Living Out Loud program serves high school girls with physical or learning disabilities, seeks to prevent

substance abuse, and encourages full participation in society.

Ms. Lopez composed a poem based on her personal experiences in which she said, "Don't pity me or turn away. Look me in the eye, and ask what you want to know. Sometimes it is not easy, but I keep going on. Nothing will stop me from succeeding, because I am a proud, strong, young woman who is on her way up!!!!" ▶

In Their Own Words



Aneka Boatwright

Patima Hunter

Youth Make a Difference

Aneka Boatwright (l.) and Patima Hunter (r.) had never met before they arrived in Los Angeles to lead a workshop for both youth and adults at SAMHSA's Second National Conference on Women. Still, Ms. Boatwright (from Savannah, GA) and Ms. Hunter (from Denver, CO) put together one of the most dynamic and interactive conference sessions under the direction of Marguerita Yancy, president and chief executive officer of Mothers & Daughters, Inc. The latter is a Denver-

based nonprofit organization dedicated to developing strong community leaders by building relationships through trust and understanding between mothers and daughters.

The workshop, titled "Young Women Speak Out on Issues Facing Their Generation," challenged the youth in the audience to predict an ending and find a solution to a case study based on a true life story. In the story, a 15-year-old girl, the 4th of 10 children, experiences sexual

molestation, beatings by her father, and the punishment of being locked in a dark room for up to 8 hours a day. After joining a gang and using drugs, she becomes pregnant, drops out of school, and moves out of her parents' house.

After guiding participants through a discussion of all aspects of the case, Ms. Boatwright told her audience: "You see, we must find solutions, and the keyword in solution is 'u' [you]. It takes each and every last one of us to come up with a solution. We're not here to tell you solutions. You have now entered the Reality Airlines. Your exits are there and there. Please do not sit on an exit row if you are not prepared to help young people rise to the occasion. Young people, please do not sit on an exit row if you are not prepared to make a difference. Thank you for flying Make-a-Difference Airlines. The solution is up to you." ▶



Don't Give Up

Youth track participant Carmen Salto of Hemet, CA, told *SAMHSA News* that the message she would like to bring other youth is, "People—especially teenagers—should not give up or commit suicide because there's a lot of things in the future—nice things—that you could live for. There's a lot of future for you." ▶

National Center Offers Women's Health Information

Have a pressing need for health information and don't know where to turn? The Office on Women's Health, U.S. Department of Health and Human Services, offers an ideal source of help through its National Women's Health Information Center.

The Center is a one-stop gateway for information and resources on a broad array of topics, including general medical illnesses, mental and addictive disorders, environmental factors such as lead exposure or indoor air pollution, and health promotion practices such as calcium intake.

Consumers of health care services, health professionals, researchers, educators, or students can obtain information tailored to their varying needs.

Just one telephone call or a visit to the Center's Web site provides access to a wealth of resources—all free. Information specialists are available (in English or Spanish) from 9 a.m. to 6 p.m., Monday through Friday. An information specialist clarifies information needs and identifies the appropriate Federal and private sector referral organizations. The information specialist can also contact Federal organizations directly on behalf of callers to order selected materials.

The Center also offers a Web site available 24 hours a day, featuring a variety of options. The two principal avenues for accessing information include "Search by Health Topic," and "Frequently Asked Questions" (FAQs).

The "Search by Health Topic" option enables users to search for information by

topic, keyword, publication, or organization name. The FAQs section provides links to a host of related questions and answers by subject, everything from acne and adolescent health to violence against women and weight loss. Just recently, 45 "easy-to-read" FAQs in large type were added.

Other options include a calendar of upcoming events (sponsored by both Federal and non-Federal organizations), the latest health news, legislative highlights, research abstracts, and health-related dictionaries and journals that may be accessed directly.

There are also specialty sections on the Web site devoted to the health concerns of women of color, resources for health care professionals, and men's health—a section to help women better understand the health issues of the men in their lives. There is also a section for speakers of Spanish, "Informacion en Español," in addition to a Spanish-language capability available through the toll-free telephone number. The latest specialty section, "Women with DisAbilities," contains information of particular interest to women with special needs.

A personal greeting from Wanda Jones, Dr.P.H., Deputy Assistant Secretary for Health (Women's Health) on the Web site urges visitors to provide feedback on the service. "Let us know how we can work better for you," she says. "After all, this new national resource was designed to



Wanda K. Jones, Dr.P.H., Deputy Assistant Secretary for Health (Women's Health), spoke at SAMHSA's Second National Conference on Women.

help ensure a healthier future for all American women."

The Web site offers an option, "What do you think about our Web site?," which enables visitors to engage in exactly that kind of interactive dialogue.

Callers and Web site users should be aware that the Center is an information referral service only, intended to educate and inform the public, and that it should not be a substitute for medical advice from a health care professional.

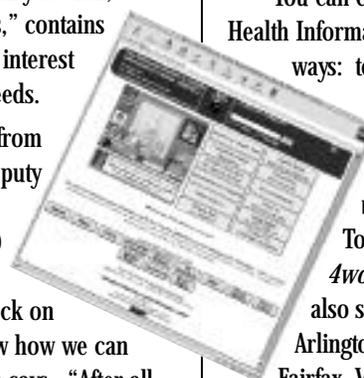
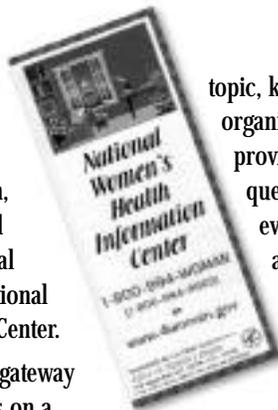
You can contact the National Women's Health Information Center in the following ways: telephone—1 (800) 994-

WOMAN (1-800-994-9662),

TDD—1 (888) 220-5446,

Web site address—
www.4woman.gov.

To send an e-mail, contact 4woman@soza.com. You can also send correspondence to 8550 Arlington Boulevard, Suite 300, Fairfax, VA 22031. ▶



Substance Abuse and Domestic Violence

A Blueprint for Care

Assisting women with co-occurring substance abuse and domestic violence problems presents service providers with complex issues. To help professionals in the field, SAMHSA's Center for Substance Abuse Treatment offers a manual, *Substance Abuse Treatment and Domestic Violence*, which is Number 25 in the Treatment Improvement Protocol (TIP) series.

The publication recommends that if a substance-abusing woman is being battered, the substance abuse treatment provider should respond to the need for safety first before developing a treatment program to help her overcome her addiction. The publication also provides diagnostic tools to help drug addiction counselors recognize when clients are victims or perpetrators of domestic violence



and to aid those who counsel abused women in need of protection to recognize alcohol and drug addiction.

In addition, the publication discusses legal issues, such as the need to deal with sometimes conflicting

Federal rules of confidentiality for patients and state laws requiring professionals to report abuse, particularly suspected child abuse.

There is little research documenting the connections between addiction and domestic violence. The consensus panel that developed the publication based its treatment recommendations on the clinical experiences of the panel members. They focused primarily on men who abuse their female partners and on women who are battered by their male partners. The panel

identified research indicating that from one-quarter to one-half of men who commit acts of domestic violence also have substance abuse problems and that at least 30 percent of female trauma patients not involved in traffic accidents have been victims of domestic violence.

The volume proposes specific reforms to link the often-separate service delivery systems for these two problems to provide more effective care.

To obtain a copy of *Substance Abuse Treatment and Domestic Violence*, TIP 25, contact the National Clearinghouse for Alcohol and Drug Information (NCADI), a service of SAMHSA, at P.O. Box 2345, Rockville, MD 20847-2345. Telephone: 1 (800) 729-6686, 1 (800) 729-6686 (se habla Español), or 1 (800) 487-4889 (TDD). To access electronically, type www.samhsa.gov, click on SAMHSA Clearinghouses, and then click on NCADI. ▶

Substance Abuse Treatment for Imprisoned Women

Women who use illicit drugs are entering U.S. jails and prisons at an unprecedented rate. To help communities and states create substance abuse treatment services for incarcerated women, and continue care as they return to the community, SAMHSA's Center for Substance Abuse Treatment (CSAT), has released a guide to creating treatment programs for female offenders.

The guide, *Substance Abuse Treatment for Women Offenders*, is Number 23 in CSAT's Technical Assistance Publication (TAP) series. The TAP emphasizes the need for continuity of care, from the presentencing period through in-custody treatment and continuing treatment in the months following release, so that women can develop the skills they need to live without drugs.

Women offenders with long-term substance abuse problems generally require residential rehabilitation, such as in therapeutic communities, yet in prisons nationwide fewer than 9 percent of women offenders receive residential treatment.

Recommendations for treatment programs include:

- Performing an indepth assessment of the woman's range of medical, substance abuse, criminal justice, and psychosocial problems while she is incarcerated and developing an individualized treatment plan. The assessment should include testing and counseling for HIV/AIDS.

- Providing substance abuse and psychological counseling throughout the continuum of treatment.
- Providing family planning counseling and training in parenting skills.
- Creating interagency agreements to address the needs of children whose mothers are in local correctional facilities.

To obtain a copy of the publication, contact the National Clearinghouse for Alcohol and Drug Information (NCADI), a service of SAMHSA, at P.O. Box 2345, Rockville, MD 20847-2345. Telephone: 1 (800) 729-6686; 1 (800) 729-6686 (se habla Español); or 1 (800) 487-4889 (TDD). To access electronically, type www.samhsa.gov, click on SAMHSA Clearinghouses, and then click on NCADI. ▶



What's New on the Web?



Girl Power!, the national public education campaign designed to help 9- to 14-year-old girls make the most of their lives, continues to extend its sphere of influence—particularly in the realm of cyberspace.

Launched in 1996 by the U.S. Department of Health and Human Services (DHHS) with leadership from SAMHSA's Center for Substance Abuse Prevention (CSAP), the *Girl Power!* campaign seeks to galvanize girls, parents, and other concerned adults, along with schools, communities, religious organizations, and health providers, to build skills and to develop competency. In particular, the campaign provides positive messages, meaningful opportunities, and accurate information about key health and safety issues.

Introduced last spring, the "BodyWise" area of the "For Girls" section of the *Girl Power!* Web site is intended to promote a positive, realistic self-image for teenage girls. "BodyWise" was developed by the DHHS Office on Women's Health through a memorandum of understanding with CSAP.

"The BodyWise area responds to growing concerns that girls are too focused on trying to look like models," said U.S. Secretary of Health and Human Services Donna E. Shalala in launching the site. "The site encourages girls to focus on positive self-images and fitness and offers authoritative information about the signs, symptoms, and dangers of eating disorders."

The *Girl Power!* Web site also offers a "Girl Power! Guest" section, updated

frequently, where influential and successful role models provide inspirational and motivational messages.

Among the most prominent is Brandy, the popular recording artist and star of the TV show "Moesha." On the Web site, she informs girls that eating the right foods and staying active are ways to stay fit.

"It isn't what others say about you," Brandy tells Web site visitors, "it's about what you say and do to yourself. Being active, like playing a sport, dancing, or exercising, are all ways you can keep fit. I take taе-bo classes to maintain a healthy body and spirit."

Other guests include astronaut Lt. Col. Eileen Marie Collins and Michelle Krusiec, the actress who plays "Sui" on the NBC television show, "One World."

The *Girl Power!* Web site has many other features, including the "For Girls! Locker," which offers skill-building games and puzzles; the "Girl Power! Diary," an onscreen diary offering suggestions and tips for stimulating creative energy; and "GirlSpeak!," which enables girls to participate in self-expression exercises. "GirlSpeak!" includes an interactive component called "What You've Said," where comments e-mailed by the girls themselves are posted.

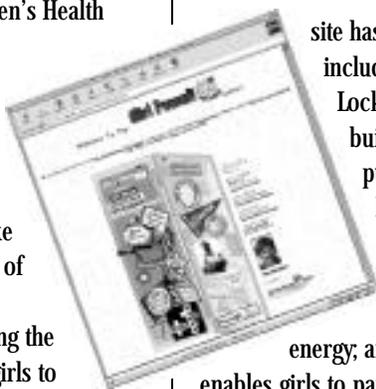
Since its inception in 1996, the *Girl Power!* Web site has received many

Internet and health industry awards. Most recently, the Web site won the spring 1999 World Wide Web Silver Health Award, and its "BodyWise" section received the Merit Award. The *Girl Power!* Web site has been recognized by SafeSurf, ABC Parenting, and Yahoogigans as a "safe" site. The Web site also offers links to other "safe," girl-oriented sites.

Girl Power! novelty items, such as baseball caps, bookmarks, posters, diaries, address book/resource guides, and buttons, can be ordered from the "Product Catalog" section of the Web site.

To obtain more information, parents and other adults can visit the area of the Web site labeled, "For Adults Who Care About Girls." They will find campaign information; related surveys, studies, and reports; and a "Hometown Press Kit," which will assist them in publicizing *Girl Power!* activities in their individual communities.

The Web site is accessible at www.samhsa.gov; click on SAMHSA's Clearinghouses, click on NCADI, and click on *Girl Power!*. Or go directly to the Web site at www.health.org/gpower. Information can also be obtained by contacting the National Clearinghouse for Alcohol and Drug Information (NCADI), a service of SAMHSA, at P.O. Box 2345, Rockville, MD 20847-2345. Telephone: 1 (800) 729-6686; 1 (800) 729-6686 (se habla Español); or 1 (800) 487-4889 (TDD). ▀



Conference Snapshots



National President of Mothers Against Drunk Driving (MADD) Karolyn Nunnallee (l.) is congratulated by SAMHSA Administrator Nelba R. Chavez, Ph.D., after her final, closing speech at the Second National Conference on Women. Mrs. Nunnallee is wearing a *Girl Power!* hat.

Following on the heels of a conference youth track request for the creation of a mentoring program, Mrs. Nunnallee told her teenage listeners, "I will tell you as a mentor . . . one thing I do hope and pray [is] that you never have my job. Because, you see, to be the national president of Mothers Against Drunk Driving, you have to be a victim, and I don't want you [to be]. I would rather you be the first female president in this country, the first female to walk on the moon, the first female to find the cure for AIDS or cancer, the first female to do anything, because you can, and I know you can.

"I want you to be—maybe—the first female to close MADD's doors because there are no longer any drunk driving crashes." ▶



Hortensia and Elvira Colorado, the founding members of the Coatlicue Theatre Company, performed on opening night of the Second National Conference on Women. The sisters have been writing, producing, and performing plays for more than 10 years.

Their presentation, *A Traditional Kind of Woman: Too Much Not 'Nuff*, comprises stories from women in the Native American community yet simultaneously speaks to the concerns of women universally in confronting such issues as domestic violence, incest, alcoholism, rape, HIV/AIDS, cancer, and nutrition.

Above, they use oversized props to satirize the prevalence of junk food, cigarettes, alcohol, and other unhealthy substances in the lives of American women. ▶



SAMHSA Associate Administrator for Women's Services and conference chair Ulonda B. Shamwell, M.S.W. (l.), meets with guest speaker Eleanor Clift, a contributing editor at *Newsweek* and a regular commentator on

the weekend television show, *The McLaughlin Group*. Ms. Clift provided an inside look at the Washington power structure and the influence of women in politics, and added, "Women are the crown jewel of the electorate today. The politicians know that." ▶



Administration for Children and Families Commissioner Patricia Montoya, M.P.A. (l.) chats with Brent Coles, Mayor of Boise, ID, and incoming President of the U.S. Conference of Mayors as of June 2000. In a speech to conference participants, Mr. Coles emphasized the need to eliminate illegal drug use, particularly methamphetamines. ▶

We'd Like To Hear From You!

SAMHSA News strives to keep you informed about the latest advances in treatment and prevention practices, the most recent national statistics on mental health and addictive disorders, relevant Federal policies, and available resources.

Are we succeeding? We'd like to know what you think.

I found these articles particularly interesting or useful:

- Women Shape a Vision for the 21st Century: A Message From the SAMHSA Administrator
- Violence: A National Problem, A National Response
- Violence Against Women: SAMHSA's Response
- Conference Highlights: Societal Context of Violence
- An Artful Approach to Change
- From Welfare to Work: Overcoming Mental and Addictive Obstacles
- Welfare Reform: Personal Perspectives
- Parental Drug Abuse in Child Welfare Cases: Tackling Dilemmas
- Family Drug Treatment Courts Offer New Option
- Concurrent Clocks Set Multiple Agendas for Women
- First Lady Addresses Women's Conference
- Women in the 21st Century: A Multicultural View
- Youth Contribute Vitality
- In Their Own Words
- National Center Offers Women's Health Information
- Substance Abuse and Domestic Violence: A Blueprint for Care
- Substance Abuse Treatment for Imprisoned Women
- What's New on the Web: *Girl Power!*
- Conference Snapshots

Other comments: _____

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Mail, phone, fax, or e-mail your response to:

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Thank you for your comments.

