



**COFO**

Consortium of  
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## DRUG ABUSE IS A FAMILY ISSUE: Family Assessment of the *Drug and Alcohol Treatment and Prevention Improvement Act of 1990, S. 2649*

### Introduction

The American public's growing concern about the nationwide problem of substance abuse intensified in the last few years when the media began reporting on the increasing number of young women who were abusing crack. Dramatic stories of crack babies abandoned in hospital nurseries and of small children fending for themselves while their parents went on day-long crack binges ignited strong — and often conflicting — public reaction.

While alcohol addiction has long been recognized as a "family disease," drug addiction had been seen previously as only a problem of individuals. However, with the advent of the crack crisis, there is widespread agreement that substance abuse in general has become a family issue. Some policymakers have focused on the need to protect drug-exposed children, others on the need to expand drug treatment services for addicted women. But, increasingly, lawmakers and administrators have begun to formulate ways to address the needs of these women and their children within a family context.

This issue of the *Family Policy Report* assesses, from a family perspective, one such family-focused proposal: sections of the Kennedy/Hatch *Drug and Alcohol Abuse Treatment and Prevention Improvement Act, S. 2649*, that specifically address issues of treatment and prevention for substance-abusing pregnant women and mothers and their children, especially Senator Christopher Dodd's (D-CT) *Children of Substance Abusers Act* (COSA bill) which was incorporated in Kennedy/Hatch as Title IV. This legislation was originally introduced in the 101st Congress and is expected to be reintroduced with few changes as part of the ADAMHA reauthorization in the Spring of 1991. The bill is examined principally from the perspective of the family criteria and family impact questions developed by the Consortium of Family Organizations (see COFO, "No title").

### Scope of Problem

The crack epidemic that began in the mid-1980s opened a new and disturbing chapter in America's efforts against substance abuse. The cheapness, easy availability, and addictiveness of the drug make it especially dangerous for the very segments of society — the poor, minorities, and especially, women — that are already struggling to cope with problems associated with poverty and family dysfunction. The subject of drug-abusing mothers and pregnant women arouses strong emotions in public debate. While everyone worries about the safety of the children and urges that they be protected, some express anger toward these women and suggest punitive remedies. There is widespread agreement that the problem of drug and alcohol abuse by pregnant women and mothers of infants and small children is serious and worsening, yet there is little research information available, beyond compelling anecdotal stories, about the extent of the problem or its long-run consequences.

Despite the staggering numbers of children affected (estimates range as high as 375,000 drug-exposed infants a year nationwide, with about 100,000 of these exposed to cocaine), many drug treatment programs will not admit pregnant women. In a recent survey of 78 drug treatment programs in New York, 54% categorically refused to serve pregnant women, and 87% had no services available for women on Medicaid. Even if programs admit women, they usually offer no prenatal or postpartum care or child care alternatives to out-of-home placement.

Preschool teachers are noticing an increase in the number of children with developmental deficits born since the emergence of crack. And for older children, the emotional, psychological, and physical effects of having a substance-abusing parent can be devastating. As a result of this worsening drug crisis and the attendant abuse, neglect, and abandonment of

infants and children, a tremendous strain has been exerted on an already overburdened child welfare system. The number of children in foster care increased 30% nationwide between 1987 and 1989. In California and New York, states especially hard hit by the crack epidemic, the increase is even more dramatic: 41% and 90% respectively.

### What Are the Family Issues Regarding Substance Abuse?

Underlying assumptions about the ways in which family members are involved in alcohol and other drug abuse and the implications of these assumptions for policy and programs constitute the framework for COFO's family impact assessment.

- When an individual abuses drugs or alcohol, all those family members closest to the abuser are affected. An abuser's withdrawal from relationships, violence directed toward loved ones, and neglect of caretaking responsibilities are all caused or exacerbated by drugs. Also, abuse often transmits across generations. *Therefore, effective policy and programs need to take these family system effects into account and work with the adult and child members of the abuser's family, as well as the abuser.*
- While the causes of drug and alcohol addiction are complex, studies clearly demonstrate that problems in family relationships play an important role in triggering or aggravating the abuse. *Effective treatment must include an abuser's spouse, sexual partner, and close relatives in some form of family counseling and/or treatment.*
- When a pregnant woman abuses drugs and/or alcohol she endangers her unborn child. When parents of infants and young children abuse drugs, the children are at risk of physical and emotional neglect and abuse — but removing all such infants and children from their homes is neither possible nor desirable. *Interventions must first attempt to help protect children within the context of their own and/or relatives' homes. Placement should be used only as a last resort.*
- Many grandparents and other relatives and non-related foster parents are caring for drug-exposed, neglected and abused children on a temporary or permanent basis at considerable disruption to their own lives. *Their needs for special support and information must be recognized and strengthened by policy and program interventions.*
- Substance abusers and their families — people whose lives are often chaotic and difficult to manage — require services that are easily accessible and user-friendly. *Treatment and prevention services need to be community- and home-based and well coordinated, such as, for example, in a "one-stop shopping" format.*

### Recent Policy Responses

In the past two years, there has been a flurry of legislative and executive response to the problem of substance-abusing women and their children. Senate and House committees have held more than ten hearings and the Department of Health and Human Services has created more than two dozen recent initiatives in both new and existing programs to address the needs of this population (see Ooms and Herendeen). Several senators and representatives introduced bills in the last session of Congress in response to hearing testimony on the seriousness of the problem of drug-abusing mothers and pregnant women and on the scarcity of treatment available for these women and their children, as well as to the publication of new reports emphasizing the cost effectiveness of treatment programs. While the attention being paid to this emerging new problem is welcome, some point out that society has long ignored the well-documented damage to infants born to alcohol-addicted women and to the children of alcoholic parents, and they urge that remedies for the crack crisis also include this larger population in need of services.

In June 1990, Senator Dodd (D-CT) introduced the *Children of Substance Abusers Act* which would establish Children of Substance Abusers (COSA) programs to increase women's access to drug and alcohol treatment and services for their children, create a home-visiting program for at-risk families, and establish training grants for professionals who work with children and families of substance abusers. Other major bills introduced last year in the Senate that addressed the problem of substance-abusing mothers and pregnant women include Senator Herb Kohl's (D-WI) *Comprehensive Assistance to Substance Abusing Families Act of 1990*, Senator Dan Coats' (R-IN) *Family Drug Treatment Grant Program*, and Senator Edward Kennedy's (D-MA) *Drug Abuse Treatment and Prevention Improvement Act of 1990*. In the House, Rep. George Miller (D-CA) introduced a bill that would have required states to provide Medicaid reimbursement for comprehensive residential treatment services to substance-abusing pregnant women, mothers, and their children. There are plans to reintroduce it this session.

In September 1990, the Kennedy/Hatch substitute for the Kennedy bill, retitled *Drug and Alcohol Abuse Treatment and Prevention Improvement Act of 1990*, was reported favorably out of the Senate Committee on Labor and Human Resources. Dodd's bill, with some minor modifications, was incorporated as Title IV of this bill.

The Kennedy/Hatch bill seeks, in the language of the committee report, "to improve existing drug abuse treatment and prevention programs and to authorize additional programs which will target scarce resources to afflicted populations and special needs" (29). Its purpose, therefore, goes beyond increasing services for substance-abusing women and pregnant mothers. The drafters of the legislation begin with the assump-

tion that although substance abuse is a treatable disease which has "devastated families" there continues to be a tremendous lack of treatment services available. The committee report cites estimates that at least 50% of the nation's 6 million addicts would benefit from treatment, but the current treatment system serves as few as 1 in 6 of this population. In recognition that the most grossly underserved addicted population remains mothers, pregnant women, and their children, several sections of the bill, especially Title IV, seek to increase services especially for them. Most importantly, this COSA bill is the first time a drug abuse bill has focused upon the *family* as the unit in need of services.

## Summary of COSA and Other Relevant Sections

The main purposes of the "Children of Substance Abusers Act," which appears as Title IV of the Kennedy/Hatch bill are:

- 1) to increase the availability of treatment for mothers and fathers who are substance abusers;
- 2) to ensure that the physical, emotional, and psychological needs of children of substance abusers, including children exposed to drugs or alcohol before birth, are identified, assessed, and addressed;
- 3) to promote the economic and social well-being of families in which a parent is a substance abuser by providing comprehensive services directed at the entire family; and
- 4) to promote the healthy development of children and preserve families by improving parenting skills and providing support systems of social services (sec. 402).

To accomplish these goals, the COSA bill relies on a 3-part strategy of establishing categorical grants to complement the more general support provided by the ADAMHA block grant:

- 1) **Services for Children of Substance Abusers (sec. 399).** The Act authorizes \$50 million a year to be administered by the Health Resources and Services Administration (HRSA) for grants to drug and alcohol treatment programs, public or private non-profit, community-based agencies, or a consortium of both to provide services to three categories of recipients. For the **children of substance abusers**, services would include periodic medical and developmental evaluation, health and mental health care, preventive counseling, and referral to related services. These services to children do not depend upon parent involvement in treatment — although that must be encouraged — and are not restricted to infants. For

**substance abusers themselves**, services would include social/psychological/economic/skills assessment; primary health and mental health care, including prenatal and postpartum care; consultation and referral regarding subsequent pregnancies and life options; remedial education services; and referral to related services. For **abusers, their spouses, and other relatives and caretakers of children of substance abusers (including parents)**, services may include therapeutic intervention, including parental counseling and joint counseling for families and children; child care and respite care; parenting education and peer support groups; support services, including transportation; and aftercare, including home visits.

The bill requires that the services funded under the grants must be comprehensive and "directed at the needs of the entire family," be accessible, confidential, coordinate with other relevant services, and use "service providers from a variety of disciplines."

According to the committee report, "the COSA grants are intended to provide an array of services that monitor and address the child's health and developmental needs while supporting the parent's ability to participate in drug or alcohol treatment" (61).

- 2) **Grants for Support Teams for Caretakers of Children of Substance Abusers (sec. 399A).** These grants, authorized at \$5 million per year, would train interdisciplinary teams (including members from child welfare, mental health, and social service agencies) to provide support for, and arrange services for, caretakers of children of substance abusers. Caretakers are defined as "a birth parent, foster parent, adoptive parent, or a relative of a child of a substance abuser." Training would emphasize the effects of prenatal substance abuse on infant care, health, and development and the methods of providing instruction and support for the caretakers.
- 3) **Grants for Home-Based Services for At-Risk Families (sec. 399B).** To alleviate some of the strain on the child welfare system, the bill authorizes \$20 million for competitive 3-5 year grants for home-based services for at-risk families defined as "a family with a pregnant woman at risk of delivering an infant with health or developmental complications or with a child under the age of 3 who has experienced, or is at risk for, such complications." Home visitors would provide health care assistance, including prenatal care; education on pregnancy, parenting, and child development; assistance in developing support networks, including the use of mentors and female role models; and assistance in finding and using necessary health, mental health, and social services (including federal programs like WIC, food stamps); respite services and family planning services. The home visitors must provide follow-up for at least one year. The home visitors must receive training

## What Criteria Should Be Used to Implement a Family Perspective?

COFO recommends that the following six principles be used as family criteria to guide policymaking (for more information see the first issue of the *Family Policy Report*):

1. **Family Support and Responsibilities:** Policies and programs should aim to support and supplement family functioning and provide substitute services only as a last resort.
2. **Family Membership and Stability:** Whenever possible, policies and programs should encourage and reinforce family, parental, and marital commitment and stability, especially when children are involved.
3. **Family Involvement and Interdependence:** Policies and programs must recognize the strength and persistence of family ties, even when they are problematic.
4. **Family Partnership and Empowerment:** Policies and programs must consider families as partners when providing services to individuals.
5. **Family Diversity:** Families come in many forms and configurations, and policies and programs must take into account their different effects on different types of families. Policies and programs must recognize the diversity of family life, neither discriminating against nor penalizing families solely for reasons of structure, roles, cultural values, or life stage.
6. **Targeting Vulnerable Families:** Families in greatest economic and social need and those judged to be most vulnerable to breakdown should have the first priority in government policies and programs.

in recognizing and addressing, or making referrals to address, parental substance abuse and its effects on children.

Among the various assurances to be provided by grantees is that they will provide "case planning for eligible families

that incorporates an interdisciplinary approach and, to the extent practical, interagency involvement."

Several other sections of Kennedy/Hatch deal directly with the issue of mothers and pregnant women using drugs, such as the following:

- Provides specific statutory authority for the Office of Treatment Improvement (OTT), and spells out its functions including collaboration and coordination with all the relevant federal health agencies and programs, evaluation of state plans under the block grant, and provision of technical assistance to state and local entities to improve treatment and coordinate services (Title I, sec. 507A).
- Amends the Office of Substance Abuse Prevention's (OSAP) grant program, developed in collaboration with the Maternal and Child Health Bureau (MCHB), for models of maternal substance abuse prevention and treatment, giving it separate statutory authorization and mandating that it coordinate its programs with Title IV. It would give priority to inpatient facilities that allow children to reside with their mothers who are in inpatient drug treatment programs, and to applicants who provide integrated, comprehensive support services for mothers and children. It also would include counseling to family members of drug abusers in group and family counseling service settings as a program priority. \$75 million per year would be authorized for this program (Title I, sec. 102).
- Establishes a National Resource and Information Center for Perinatal Addiction to consolidate state-of-the-art information on research, policy, and training in the area of perinatal substance abuse and to fund studies on fetal cocaine syndrome and its long-term effects (Title I, sec. 102).
- Establishes a \$5 million program for Public Education Regarding Drug and Alcohol Use During Pregnancy (Title I, sec. 509K).
- Title I would make comprehensive treatment for women one of the priorities in the Demonstration Grants for Drug Treatment in the Criminal Justice System (sec. 5091).
- Revises and amends the Alcohol, Drug Abuse, and Mental Health Administration (ADAMHA) block grant to include an increase in the set-aside for the treatment of women, especially pregnant women and women with dependent children, from 10% to 15%. (Dodd's original COSA bill called for the set-aside to be 20% and substance abuse treatment for pregnant women to be available on demand.) Also, the block grant monies may be used to provide "counseling to family members of drug abusers, including such family members in group and family counseling

services settings for the treatment of drug abusers” (Title II, secs. 202 & 203).

- Title III, Pharmacotherapy Development, would establish as a high priority research area the development of medications to treat pregnant addicts and their offspring and fetuses.

## Assessment of the Family Impact of the COSA Bill and Other Relevant Sections of the Kennedy/Hatch Act

The COSA bill clearly intends to provide substance abuse treatment services in a manner that strengthens the family. This assessment asks family impact questions based on six key family criteria developed by the COFO (see box on page 4) in order to examine the extent to which the provisions and specific language of the bill are likely to achieve this goal.

### 1. Family Support and Responsibilities

**Does the bill support and supplement parents' and other family members' ability to carry out their responsibilities?**

Yes. Throughout both the service and training provisions, the bill clearly seeks to support rather than supplant family members in their caretaking roles. This is accomplished through the funding of various practical support services (such as child care and transportation), in-patient and out-patient drug treatment services and referrals, educational services to improve parenting skills, and psychological counseling services. The goal of the services and focus of the training is to encourage improved parental functioning thereby protecting and enhancing the development of the children.

However, the COSA bill omits to include a mention of services and training specifically targeted to deal with a very common and serious problem in substance abusing families—namely, conflict and violence between spouses and sexual partners.

**Does the bill provide incentives for other persons to take over family functioning when doing so may not be necessary?**

No. In fact, the bill properly seeks to do the opposite, to redirect incentives toward efforts to preserve the parent's autonomy and responsibility. Services grants are to be distributed among different types of entities that provide residential, community-based, and in-home services. The residential facilities to be funded should allow the children to remain with their parents during treatment. The committee report expressly states “COSA grantees, where appropriate, may act as advocates for parents and children participating in the program and that child welfare agencies will draw on the COSA services to

help prevent placement in foster care or promote reunification of families” (62).

The grant program for home-based services for at-risk families would provide intensive intervention to prevent placement. And in the revision of the OSAP grant programs a funding priority has been added for programs that treat women in residential settings in which their children may reside with them. These are all crucial steps in the reconceptualization of substance abuse treatment. Research indicates that by separating a mother from her children you disempower her, discourage her, and remove her primary incentive for recovery.

**What effect does the bill have on parental obligations?**

Overall, the bill encourages “parental” responsibility, and yet the services it funds are geared primarily towards mothers—although fathers are not precluded. While increasing treatment availability for mothers *and* fathers is listed as a goal of the legislation and the OSAP revisions call for “strategies to involve male partners,” husbands and fathers are rarely mentioned specifically and most of the programs and services seem oriented to mothers alone. For instance, although the legislation calls for mothers and children to be together during treatment—a giant step forward—there is little mention of the status of a substance-abusing father, of maintaining his relationships in the family, or of addressing his family responsibilities. Perhaps, this reflects, in part, the realization that existing drug treatment facilities largely treat men. However, existing programs do not focus on addicts as fathers or as having family responsibilities.

One provision in the COSA bill would provide services more relevant to fathers' needs, but only where they too are substance abusers. Services for children of substance abusers includes assessment of adult roles other than parenting, including periodic evaluation of social and economic status, education, psychological condition, and skill level, and provides remedial education and referral to related services (sec. 399).

Title I, sec. 509K, of the Kennedy bill, which authorizes \$5 million for a public education program regarding drug and alcohol use during pregnancy, specifically targets “women of child-bearing age and their male partners” but does not mention husbands.

### 2. Family Membership and Stability

**What incentives or disincentives does the bill provide to marry, separate, or divorce?**

None. The language makes no reference to marital status in determining eligibility for services. However, as noted above, an opportunity is missed to provide marital/partner counseling and to help strengthen often problematic relationships, which in some cases of married couples might help prevent divorce or, in

**What services are provided to help family members living apart remain connected and, if appropriate, come together again?**

While COFO is encouraged by the availability of services to both parents and caretakers of children of substance abusers — the emphasis on home-visits, avoidance of placement, aftercare, and the reunification of families — there should be some provision describing the relationship between the foster caretaker and the substance-abusing parent who has temporarily lost custody of her/his children. Although typical child welfare practice has been to keep foster parents and biological parents apart, family professionals increasingly believe that a key part of family reunification efforts is establishing good communication and positive direct contacts between the foster caretakers and birth parents in order to sustain the parent/child ties and facilitate successful reunification (see Minuchin). Thus, one question in the implementation of these provisions is whether the “joint counseling sessions for families and children” mentioned may include foster caretakers *and* parents meeting together? Also, do the confidentiality guarantees present needless impediments to communication between foster caretakers and substance-abusing parents?

The \$40 million demonstration grant program for Drug Treatment in the Criminal Justice System, administered by OTI (Sec. 509I), establishes a range of services for female offenders as one of the priorities. While these services include alternatives to incarceration, there is no mention of services designed to enable inmate addicted mothers to keep their infants in prison with them, to help children, spouses or other family members visit their addicted relatives in jail, or to encourage weekend furlough programs. Programs that strengthen inmate/family contacts have been found to greatly reduce recidivism and certainly help the children to withstand the separation from their parents.

### **3. Family Involvement and Interdependence**

**To what extent does the bill recognize the influence of the family context upon the individual's need or problem?**

This is one of the strongest features of the bill. The drafters of the legislation clearly view maternal substance abuse as a family problem rather than only an individual problem — that is, the behavior of one person, the substance-abusing parent, has a direct effect on the health and development of the children and on family well-being overall. All the services are organized around the context of the family in an effort to keep the mothers and children together, services are community-centered and often home-based, and treatment includes the skill-building necessary for the substance abuser and her/his family to create a drug-free family environment.

**To what extent does the bill involve immediate and extended family members in working toward a solution?**

By providing services to a broadly defined group of caretakers, the bill recognizes the roles of other family members. Many grandmothers, for instance, are providing care in the child welfare system — often without adequate support. If comprehensive support services are available to a grandmother, she will be encouraged to provide interim or long-term child care for grandchildren whose parents are substance abusers. More could be done, however, to encourage explicitly the enlistment of non-parent relatives as the primary resource of foster care.

**To what extent does the bill acknowledge the power and persistence of family ties, especially when they are problematic or destructive?**

The knowledge that family ties are powerful, persistent, and important — even when they are as destructive as in the case of substance-abusing families — is the philosophical underpinning behind family preservation and the COSA bill. This bill offers programs that seek to maintain family ties, especially between mothers and their children, while making them less destructive.

**How does the bill assess and balance the competing needs, rights, and interests of various members of a family?**

Fortunately, the COSA bill transcends the usual construction of the debate — fetus/child welfare v. mother's rights — and envisions the problem as frequently resolvable within families as long as they receive the necessary support (treatment services, education, home visitors, etc.). However, as noted above, the bill makes no contribution to helping service providers know when it is safe to leave a child in his/her family setting, how to structure for safety, or when to refer to child protective services for out-of-the home placement.

There is a growing body of program knowledge both about how to assess the level and severity of parental substance abuse and its potential danger to children and about appropriate criteria for removal, which needs to be made more widely known. Programs are also learning how to employ strategies to mobilize non-abusing family members and neighbors to help assure child safety until the abusing parent becomes engaged in treatment and is deemed capable of resuming sole caretaking responsibilities (see Ooms & Herendeen and Besharov).

### **4. Family Partnership and Empowerment**

**In what specific way does the bill provide full information and a range of choices to individuals and their close family members?**

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### **4. Family Partnership and Empowerment**

**In what specific way does the bill provide full information and a range of choices to individuals and their close family members?**

The home-visiting and training for support teams provisions emphasize the need to help families work through and access the often confusing morass of social services available to them. In order for families to have a full range of choices, four conditions must be in place: a range of treatment options and services must exist (e.g., inpatient, day treatment, outpatient etc.); families must know about them; families must have physical and financial access to them; and families must be allowed to make their own choices.

Several provisions in this bill address these different aspects of choice—especially the increased accessibility provided through the outreach, home visiting, and transportation services. The COSA bill does not mention any income eligibility requirements or fees although the OSAP model projects provisions state that no fees can be charged to women under the poverty level. Since more treatment services will be funded, hopefully a greater variety of options will exist, and the options will be tailored for the needs of parents with children. However, the lack of any coordinated local planning mechanism, together with limited funding, suggests that many communities will not have a full range of services to offer families, though the range should certainly improve over the present.

Another critical service delivery tool which greatly facilitates choice is effective case management. Although the training grants require instruction “oriented toward case management” and “case planning” is listed as a priority for the home-based service grants, the COSA bill does not clearly establish the principle of requiring a primary case manager for each family to coordinate multiple services needed. The OSAP model projects includes case management services in its list of services eligible for grant funding (sec. 102).

Integration of services greatly increases the range of effective choice for families. The Kennedy/Hatch bill calls for coordination of grantmaking across federal programs on the federal agency level through the Office of Treatment Improvement. It also requires the integration of COSA services on the local level, “the entity will .... [incorporate] an interdisciplinary approach and, to the extent practicable, interagency involvement” (sec. 399B), but provides no specific mechanisms to accomplish this.

#### **In what ways do program professionals work in collaboration with the families?**

The home visiting program in the bill is a potentially useful way of building the collaboration between families and professionals which is a critical element of effective treatment. As Dr. Amy B. Wheaton, Commissioner of the Connecticut Department of Children and Youth Services, explained in a hearing before the Senate Subcommittee on Children, Family, Drugs and Alcoholism in March 1990, “By visiting the home the worker can observe family dynamics and assist the family

members in correcting dysfunctional behaviors as they occur. Besides being a powerful assessment tool, the act of providing services in the home gives the family a feeling of being ‘in charge’ of its destiny and is a clear indication of the respect the social worker has for the family” (“Falling through...” 119). However, training is needed to help workers know how to use and conduct home visits in order to realize this potential.

The committee report emphasized their intent that there should be continued follow-up by home visitors: “the relationship between the program and the families it serves [should] be long term in nature” (62). The specific requirement is for at least a one-year follow up.

In the bill, the language referring to the type of professionals who may provide services is deliberately broad, interdisciplinary, and comprehensive. As noted in the committee report, while they intentionally declined to define “treatment professionals” in the bill, they felt the term encompassed, at a minimum, “therapists and counselors in addition to physicians, psychologists and nurses” (52). COFO finds the breadth of this definition encouraging, but believes professionals specifically trained to work with families should be included in this list.

#### **In what ways does the bill involve parents and family representatives in policy and program development, implementation, and evaluation?**

The bill contains no provisions that would include consumers and family representatives in the development of federal, state, and local policy, and in the implementation and monitoring of treatment programs. This is a major omission in a family-oriented bill. It should be noted that currently the ADAMHA block grant does not request states to emphasize patient/family participation although some states, in fact, choose to do so. However, the NIMH Child and Adolescent Service System Program (CASSP), begun in 1984, does include a strong emphasis on involving the parents in policy development and implementation in services for seriously emotionally disturbed children.

Although COSA contains relatively stringent reporting requirements for grantees on aspects of service populations and program effectiveness, the information is to be sent only to the federal government and not to the public or representatives of consumers.

Program evaluation requirements in the legislation include the collection of data about the numbers and types of families served, services received, and effects on child placements rates but does not mention the need to assess programs’ effects on parent and family functioning. Since improvement in parental and family functioning is an important goal of this legislation, this is a regrettable omission.



## 5. Family Diversity

**If the bill targets only certain families, what is the justification? Does it discriminate against or penalize other types of families for insufficient reason?**

To be eligible for the home-based services a family must include an at-risk pregnant woman or a child below the age of three who has experienced, or is at risk for, a health or developmental complication. Such targeting makes sense since these are the neediest populations. However, such home-based support services would also be useful to families with older children. The committee report also states that “grantees demonstrate a commitment to serving low-income families, including those without health insurance” (62-63). However, it is unclear if families with health insurance would have access to these services. OSAP’s model project grants allow for fees to be charged to women who are above the official poverty line but does not specify what kind of charges or whether they are on a sliding scale. Many “working poor” families — often barely above the poverty line — are in desperate need of the types of services COSA would provide and should be eligible for them.

**How does the bill identify and respect the different values, attitudes, and behavior of families from various racial, ethnic, religious, and cultural backgrounds that are relevant to program effectiveness?**

The home-based services program portion of COSA is the only section that explicitly addresses the issue of cultural sensitivity. It requires that grantees be “familiar with the socio-economic and cultural groups” they serve and “deliver ... services in a manner that accords proper respect to the cultural traditions of the eligible families” (22). The home-based services program also allows home visitor teams to be made up of trained lay people led by at least one professional. This would be an excellent opportunity for community-based programs to tap into the talents and cultural identity of their communities and make their programs more responsive and sensitive to their service populations. In areas serving minority populations, every effort should be made to recruit minority treatment professionals to lead the home visitor teams. One particular provision of the home-based services grant which could increase cultural empowerment emphasizes the importance of “developing support networks, including mentors and other female or maternal models” (sec. 399B).

## 6. Targeting Vulnerable Families

**Does the bill identify and target publicly supported services for families in the most extreme economic or social need and preventive services to families who are most vulnerable to breakdown?**

As mentioned in the last section, the COSA bill contains outreach programs to identify and target at-risk families. It identifies targeting priorities as low-income families and areas “with a high incidence of poverty, substance abuse, infant mortality and child abuse” (47). Other sections of the Kennedy/Hatch bill that target the most vulnerable families include the increased ADAMHA block grant set-aside for women and the increased priority for women and children to reside together during inpatient treatment. It does not, however, identify areas or sub-groups that are presently underserved, such as the Native American population or families in rural areas.

## Recommendations

Overall, the Kennedy/Hatch bill, especially the COSA provisions, is strongly family-oriented in its approach to drug abuse prevention and treatment for pregnant addicted women, substance abusing parents and their children. The creation of family-centered policy requires more than just noble intent and the use of the correct buzz words; it requires a vision of families as the basic unit to which services are provided. This bill was obviously crafted from the very beginning with a family focus in mind.

However, COFO believes that the family orientation of Kennedy/Hatch can be strengthened further by the following additions and modifications:

### Definitions

COFO recommends two definitions be included in the COSA bill:

- (1) **Substance abusers should be clearly defined as those who abuse alcohol and other drugs.** The problem of maternal alcohol abuse, which has existed for many years, has largely gone unnoticed and needs highlighting. While it is the clear intention of the act to include alcohol abuse, field experience suggests that in some states and communities drug and alcohol programs are often administratively separate and funded from separate categorical programs, leading to unnecessary competition for these funds. It is also important to emphasize that alcohol is a drug.
- (2) **Case managers should be defined as individuals who assess the needs of an individual and family for services; assist them in obtaining these services; and help in the coordination, brokering, and monitoring of services as needed.**

### Services

COFO recommends that several family-oriented services should be specifically added to the various sections of the bill where services are listed. These additional services should include:

- case managers assigned to every family
- family assessments
- partner and marital counseling
- family therapy
- mediation and conflict resolution services
- for incarcerated parents, family visiting programs, weekend furloughs, and infant living-in programs.

A model for creating family assessment requirements is P.L. 99-457, the Education for the Handicapped Amendments Act of 1986. Part H of the law requires that a written Individualized Family Service Plan (IFSP) be developed for each eligible child which must include an assessment of his or her level of development and needs and, at the family's option, a similar assessment of the family's strengths, service needs, and expected outcomes of the intervention for both child and family. Family assessment, an important part of effective case management, helps tailor service programs to the specific needs of families.

It should be noted that Senator Coats' bill to establish a Family Drug Treatment Grant Program, although only funded at \$3 million per year, did include a specific provision calling for the use of "intensive family therapy."

Substance-abusing families require intensive services which require time. Thus, COFO recommends including a provision about recommended caseloads for home-based program workers and case managers. The purpose of the legislation and any training is nullified if workers have high caseloads.

### Training

Training of service delivery professionals is a vital component of expansion of treatment. If professionals are not adequately trained the goals of the new law cannot be achieved. Since the population of families with substance-abusing parents presents many new and complex challenges to most health and mental health professionals, COFO believes their training needs should be given even greater attention in the COSA bill. The current curriculum guidelines (under sec. 399A) are too limited and do not include many of the new knowledge and skills necessary to effectively provide services to this population.

COFO recommends adding to the current list of curriculum requirements for the training grants (for support teams for caretakers) the following:

- family assessment and counseling
- marital and partner counseling
- assessment of the nature and degree of substance abuse
- understanding the process of addiction recovery, including co-dependency issues
- child risk assessment, including family violence assessment
- conflict resolution/mediation services

- information about types of alcohol and other drug abuse treatment programs suitable for this population
- indications for referral for intensive family therapy and other mental health services (e.g. for depression)
- "normal" child development, that is, age-appropriate developmental expectations
- knowledge about health issues, including high-risk pregnancy and drug-specific medical problems.

### Coordination/Integration of Services

As noted, the Office of Treatment Improvement is directed to collaborate with many other federal offices and agencies and to work to coordinate services at several levels. Coordination is a highly touted goal, but experience shows that it is very difficult to accomplish in practice.

COFO recommends that the legislation should include a requirement to establish some specific mechanisms and financial resources to accomplish the desired coordination of services. For example such mechanisms might include: the development of interagency task forces (including representatives from "front-line" service agencies and parent advocacy groups), interagency agreements, decategorization, and commingling of funds. The federal government should also provide financial incentives and target specific resources for state and local governments to spend on coordination activities.

As an example of such mechanisms, Senator Kohl's bill established institutional integration through these provisions: 1) creation at the federal level of Interagency Committee on Parental Drug and Alcohol Abuse which would coordinate all research, prevention and treatment, health care and social services, educational programs, and other activities within the various federal agencies that relate to children, youth, and families at risk due to parental drug and alcohol abuse; 2) a \$150 million authorization for Comprehensive Family Preservation Service Grants which includes requirements that statewide systems of coordinated, comprehensive, multidisciplinary, interagency programs be established. Also, P.L. 99-457, Part H, requires federal and state level Interagency Coordinating Councils to be set up to play a critical role in implementation of the legislation.

### Family Involvement in Policy and Evaluation

COFO believes that for a program to be truly community-based and responsive to family needs family advocates — parents and other family representatives who have had personal experience of the problem in their families and, therefore, have expertise — must be involved in the policy development and monitoring process.

COFO recommends that the legislation should include mechanisms to assure that program participants and community members are involved in assessing the grants pro-

grams' effectiveness, and in developing state plans for ADAMHA Block Grant funds. Again, P.L. 99-457 is a useful model for such requirements, as is the CASSP/NIMH program and Head Start.

### Targeting At-Risk Populations

The home-based services grants are specifically designed for a sub-group of the overall "at-risk" populations, namely families with infants and very young children under age 3. Given limited funding resources, studies in the field of early intervention provide support for this targeting on the youngest age group. This is the time when primary relational attachments take place and when maltreatment can most deeply affect cognitive, social, and emotional development in a child. The other services portion of the bill is available for children (of substance abusers) of any age. The bill also requires grantees to target low-income groups, but, unlike Senator Kohl's bill, does not include any effort to increase their access to related services (such as by expansion of Medicaid coverage to include programs which allow the children to reside with their mothers.)

COFO recommends retaining the present priorities in the home-based services program but adding specific sub-groups at special high risk to be given priority for funding, such as Native Americans, who have such an unusually high incidence of children born with fetal alcohol syndrome, and those in rural and semi-rural areas who are often underserved.

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## COFO Family Policy Report

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The *Report* is published quarterly in the spring, summer, fall, and winter and addresses current legislation and programs that affect families. Correspondence and requests for subscriptions and back issues may be addressed to the COFO Coordinator, c/o FSA Office on Governmental Affairs, 1319 F Street, NW, Suite 606, Washington, DC 20004, 202/347-1124. Subscriptions are \$12.00 annually.

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