

AIA

BEST PRACTICES:

Lessons Learned from a Decade of Service to Children and
Families Affected by HIV and Substance Abuse



National Abandoned Infants Assistance Resource Center
School of Social Welfare
University of California at Berkeley

—2003—

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A Service of the Children's Bureau

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Dedication

This monograph is dedicated to Judy Pack (1945-2003) our colleague and friend. Judy's enthusiasm, ambition, good nature, and commitment to the AIA program and this monograph were an inspiration to all of us. We will remember her strength and fighting spirit not only in battling cancer, but also in serving those who needed help the most. Judy was a pioneer in the field of helping women and children who are affected by AIDS and substance abuse. She provided encouragement and hope to these women and children when no one else would and provided services when no one else could. Judy was special because she saw no one as ordinary. We were privileged to have worked with her.

Preface

JEAN ADNOPOZ

In response to the hospital boarder baby phenomenon of the late 1980's, where infants affected by HIV or substance abuse were abandoned in hospitals by their mothers, the United States Congress enacted the Abandoned Infants Assistance (AIA) Act. This legislation established a discretionary grant program to support demonstration projects across the nation that would prevent abandonment and promote permanency, well-being, and safety for children from families struggling with substance abuse and/or HIV.

Although the Abandoned Infants Assistance Act has funded numerous projects since fiscal year 1990, this monograph was written by administrators of ten originally funded projects that continue to serve HIV and/or drug affected children and families, the director and staff of the National AIA Resource Center, and the Federal Project Officer. The authors, who have met annually since the first grantees' meeting in 1991, believe that the lessons derived from their experience with this population are worthy of widespread dissemination. This volume reflects a shared understanding that has emerged from careful analysis, discussion, and a willingness to expose to scrutiny work that has gone well, as well as that which has been unsuccessful.

Safety and security are issues for every child served by an AIA project. Many children have been separated from their biological parents; others are vulnerable for separation. All of them may be subject to multiple placements and the difficulties that may ensue from disruptions in their primary caregiving attachments. AIA projects assist these children to remain with their families, whether biological, kinship or foster, when feasible and in the child's best interest. The collaborations that join AIA projects with child protection agencies and other community providers are critical to this process. The ability to tolerate uncertainty and support risk taking when it is in the child's interest requires close working relationships, an acceptance of the limits of our knowledge and a willingness to move beyond harsh and judgmental stereotyping.

All of the original projects have discovered that many HIV and/or drug affected families are able to benefit from an array of in-home and community-based services; even families with severe psychosocial problems have been able to respond effectively to interventions that are sensitive to their needs. These families have the capacity to change their behaviors and act in the best interests of their children when provided with supportive, accepting, client-driven, family-focused services.

The chapters that follow describe the aims, assumptions, and principles that have guided the ten of the original projects. The intent of this volume is to support the application of the lessons learned from the first decade of experiences and cross-site evaluations to policy development and program planning for drug and HIV/AIDS affected infants and children vulnerable for abandonment and their families. In the process, the reader will become familiar with the broad scope of the innovative, national efforts to achieve permanence for children and will hear from the families who benefited.

Based on the projects' experience, the following elements often predict successful outcomes:

- Flexibility in service provision; and
 - Trained, well supervised, and supported staff members, and home-based, nonjudgmental intervention strategies that are barrier free.
-
- Careful risk assessment that reflects an understanding of the physical, psychological, cognitive and emotional needs of infants and children;
 - Development of a therapeutic alliance between the family and service providers built upon mutual trust and respect;
 - Identification of parental strengths and a willingness to build upon them;
 - Active involvement of parents in treatment planning and goal setting;
 - Comprehensive, individualized treatment plans for family members
 - Strong interagency and interdisciplinary collaboration;

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Ms. Abruzzino has worked in the field of child welfare for over 20 years. She has managed an AIA project focusing on HIV infected/substance abusing women who were at risk of having their children removed from their custody. Ms. Abruzzino has also specialized in providing adoption services to families interested in creating permanent homes for special needs children. She has also participated on Technical Expert Groups (TEG) on voluntary relinquishment, and family planning and child welfare.

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During her many years with the Illinois Department of Children and Family Services, Ms. Bridgeforth served as project director for several HIV Respite Care Grants and several AIA grants spanning 10 years, including Project Aban, which has completed its grant cycle. Until she retired, Ms. Bridgeforth was the Project Director for Promoting Safe and Stable Families, which in Illinois is the Family Centered Services Initiative. She has a BA degree in Education and an MA degree in Counseling.

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As an attorney, Ms. Coon has focused much of her legal work on permanency planning for HIV affected families. She has co-authored Illinois' standby guardianship and short-term guardianship laws, and coordinated advocacy work that led to their passage. She also authored Illinois' new standby adoption law, the first in the US. Ms. Coon is the Legal Services Director of the AIA-funded Family Options Project in Chicago, a program of legal and social work services for HIV affected families who wish to make and carry out permanency plans for their children. She is also President of LSC and Associates, which provides program development, support and evaluation services for child welfare, youth services, and HIV/AIDS agencies.

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Ms. Pack, a graduate of the University of Tennessee, School of Social Work, has dedicated her life to improving the welfare of East Tennessee children and

families for more than thirty years. For the past ten years, hired as project director during the initial start up of the program, she, and her staff, developed Great Starts to become the leading edge-innovative program it is today for drug-exposed infants and their drug addicted mothers. Formerly, Ms. Pack worked in the private sector, specializing in quality improvement and employee involvement for a Fortune 500 company. In her early career, she worked in the public welfare arena in adoptions, foster care, and protective services. In 1998, Ms. Pack was selected as a participant in a Community Leadership-Knoxville class. Throughout her career she has served on boards of several organizations in the East Tennessee area, and though currently retired, continues to advocate for children.

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Ms. Towns is the Deputy Executive Director for the Abandoned Infants Assistance project, Project B.A.B.I.E.S, a community based residential program for drug exposed infants, who are at risk of abandonment and an Outpatient/Aftercare program for women and their children 0-4 years of age in Newark, New Jersey. In addition, she has administrative responsibilities for the agency's 22 - bed residential programs for at-risk adolescents that are referred by the NJ State Division of Youth and Family Services. Her experience includes over 21 years of working in the area of Child Welfare, mental health, residential foster care, and substance abuse. Ms. Towns received her B.S.W. and M.S.W. from Adelphi University, Garden City, New York. She is a Licensed Clinical Social Worker in New Jersey and a Certified Social Worker in the State of New York.



Descriptions of AIA Projects*

Coordinated Intervention for Women and Infants

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The Coordinated Intervention for Women and Infants (CIWI) is a collaborative program to prevent the abandonment of infants and children affected by maternal substance abuse. CIWI provides child focused, home based, clinical intervention, prevention, and supportive services to substance abusing mothers and their families to ensure the safety and well-being of children and the stability of their caretakers. CIWI utilizes a team, consisting of a clinician and a family support worker, which provides a range of clinical and concrete services. In collaboration with Yale New Haven Hospital, CIWI provides a continuum of care based on the clients' needs.

* This list includes only those projects participating in the completion of this monograph. For a current list of Abandoned Infants Assistance grant funded projects, please check the National AIA Resource Center's web site: <http://aia.berkeley.edu>

Intensive services are provided in the home; while center based services are offered through the hospital clinics. AIA funds are also used to support the Yale Program for HIV-affected Children and Adolescents, which provides clinical services to HIV-affected families, both in the home and through groups in the community. As part of the goal to promote permanency, the program, when appropriate, assists parents to utilize the state's co-guardianship statutes to ensure the continuity of care, stability, and child safety.

Family Centered Services' Home Visitation Program

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The Family Centered Services' Home Visitation Program is an intensive home visitation and case management service for parenting women at risk of abandonment or out-of-home placement of their children. The program is a major component of the family-centered care model of service that also includes Early Head Start, nutrition services, and HIV testing and prevention education. The families served through home visitation/case management are

pregnant or parenting women who have at least one child under age three, who receive no other home visitation services, and who have one or more of the following risk factors: substance abuse; homelessness; HIV/AIDS; mental health concerns; domestic violence; or child abuse/neglect.

Family Options

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AIDS Project
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Family Options provides comprehensive permanency planning services for families affected by HIV/AIDS. This includes in-home social work and counseling services to families before, during, and after the planning process. Legal services and representation facilitate clients' movement through the court system to a permanent legal plan. The program will also develop and implement policy within the systems that families need to use to make plans.

Great Starts

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The project serves cocaine and other drug using women, who may be HIV+ and who are pregnant or have given birth to drug-exposed and/or HIV positive children. Intensive outpatient treatment services, life skills development, and aftercare/follow up services are provided for residential and day treatment women. Great Starts provides housing for up to six

months for a minimum of 22 women and 37 children, from birth through 10 years of age. Therapeutic nursery services are provided for drug/exposed infants, toddlers, and preschool age children.

Los Pasos

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Los Pasos offers an interdisciplinary, multi-agency program for infants and families affected by prenatal substance abuse. Los Pasos (Spanish for "steps") builds upon the strengths of families considered to be at risk for abuse and neglect by following a step-wise model of service delivery. These services, which are also provided to the siblings of "index" children, are provided in the homes and at clinics and include: the delivery of preventive health care to these infants and their families at a weekly clinic; developmental monitoring of children until their third birthday and referral to early intervention services where indicated; training of parents regarding child development and special considerations for children with developmental issues; assistance for families with social service, legal, and substance abuse prevention needs; and coordination with programs and agencies both within the University of New Mexico Health Sciences Center and the community. All services are delivered with consideration of and respect for the cultural values of each family. Program philosophies, which guide the planning and delivery of services, include harm reduction, models of solution-focused intervention, and interdisciplinary practice.

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The Resource Center's mission is to enhance the quality of social and health services delivered to infants and young children affected by drugs or HIV, and their parents, by providing training, technical assistance, research, resources and information to professionals who serve these families.

Project Aban

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Project Aban forms a service partnership between the Illinois Department of Children and Family Services and the Cook County Hospital Women and Children's HIV Program. Project Aban seeks to embrace the family with practical, emotional, and physical supports in an effort to build family stability, and successful parent and child development. The word "aban" is an African word/symbol for fence, which provides safety and security. Project Aban's emphasis is on intensive in-home services, early infant/child intervention, peer support, chemical dependency recovery support and parent education.

Project Aban constructs a secure and nurturing environment for families affected by HIV. (Project Aban's participation in the AIA program ended in 2001.)

Project B.A.B.I.E.S.

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Project B.A.B.I.E.S. (Boarder and Abandoned Babies: Intervention, Education and Services) is a model program providing immediate shelter and comprehensive on-site support service for at-risk infants and their mothers. The residential care program offers round-the-clock care for up to four drug-exposed infants. The out-patient/after care component works with up to 30 mothers in the community who are at risk of losing their infant/toddlers due to drug use. Both components incorporate case management and counseling services for the family, substance abuse counseling and education, random drug testing, developmental assessment and monitoring for the infant or toddler, hands-on parent training, mother/child groups, prenatal support services to stabilize mothers at risk of infant abandonment, post-partum outreach to mothers, and transitional housing for mothers and infants. The follow-up services include home visits, case management, and in-home services. The program also has developed a multi-agency consortium to coordinate services for drug-exposed infants at risk of abandonment and their families.

Project Prevent

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Project Prevent's goal is to decrease the incidence of infant abandonment through a program of primary and secondary prevention with substance using women. The project works with pregnant women and those women who have delivered an infant admitted to one of the neonatal intensive care nurseries within the Emory Regional Perinatal Center. Teams, consisting of a social worker and an addiction counselor, work with the client/family from point of referral for two years. Barriers that interfere with utilization of treatment, medical care, and other services are identified and a plan to help overcome these barriers is developed. Upon the birth of the baby, developmental and physical health services are coordinated with "partner" agencies. Home visits, outreach, teaching and multi-agency collaboration are integral parts of Project Prevent's approach to providing comprehensive services.

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Project SAFE (Stopping Abandonment through Family Empowerment) is committed to decreasing the incidence of infant abandonment by strengthening families. The mission of the program is to plan, deliver, and evaluate a child-centered, woman/family focused, comprehensive early intervention program to women and their children in order to improve

their quality of life by reducing substance abuse, and the risk of HIV transmission; providing stability, safety and permanency planning; expanding male caregiver involvement; and enhancing mental health and health functioning. Under the auspices of Children's Home Society, University of Miami (UM), and Barry University (BU), and in conjunction with a consortium of local social services agencies, Project SAFE provides a network of community resources to Project SAFE clients and their families. Project SAFE employs an innovative strategy of client engagement by utilizing peer support to provide community-centered, home-based service delivery.

TIES Program

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The TIES (Team for Infants Endangered by Substance abuse) Program strives to remove the barriers that prevent women from getting treatment for addiction and to secure protection and medical compliance of pregnant women and infants born to drug involved women. This intensive, multi-agency approach provides services to pregnant and postpartum women and their families whose infants are prenatally exposed to HIV, alcohol or drugs. Activities include in-home counseling and support, drug treatment referrals, connection to primary health care, emergency assistance, parenting education, transportation, and linkage with other community resources. The program also provides child developmental assessment and services, childcare, and support groups for women and for relative caregivers. Community training is available for those who serve a drug involved population.

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Introduction

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The Genesis of the Federal Abandoned Infants Assistance Demonstration Program

The co-occurring crack cocaine and HIV epidemics of the late 1980's gave rise to a dramatic increase in the number of infants exposed to drugs and/or HIV in utero and also led to staggering numbers of "boarder babies" and "abandoned infants" residing in hospital wards throughout the country. Boarder babies and abandoned infants remained hospitalized because of their parents' inability to provide appropriate care and the child welfare system's incapacity to promptly investigate their circumstances and locate alternative residential placements for them. Hospitals and child welfare agencies struggled to address systemic barriers, develop helpful supports for families, and find suitable placements for these children, but they often lacked the necessary resources and knowledge to do so.

In 1988, Congress enacted Public Law 100-505, The Abandoned Infants Assistance (AIA) Act, to respond to the boarder baby and abandoned infant crises. This legislation authorized the U.S. Department of Health and Human Services (DHHS) to establish a discretionary grant program that would spawn the

development of service demonstration projects.

These projects were expected to prevent abandonment; identify and address the needs of abandoned infants and young children, particularly those with AIDS, and their families; and assist the families and their children to remain together or to locate suitable alternative care.

Public Law 102-236, in 1991, amended the original legislation by expanding the target population beyond infants and young children infected with or exposed to HIV to include those exposed prenatally to illicit drugs. The law also promoted the concept of comprehensive service sites, offering health, education, and social services at a single geographic location in close proximity to where the infants resided. Additionally, it underscored the need for prevention, encouraging the provision of services to all family members for any condition that increased the probability of abandonment. In 1996, the AIA Act was authorized for an additional four years (Public Law 104-235) under the Child Abuse Prevention and Treatment Act and emphasized expedited permanency for infants.

Initial Design of the AIA Projects

The primary focus of the AIA demonstration projects was to address the needs of children and families affected by perinatal substance abuse and/or HIV. Each AIA project was unique, reflecting the diverse cultures, communities, and ethnic background of the clients they served. They varied, as well, with regard to their service origins, their referral base, and the family constellations they served. For example, they were hospital-based or community-based; the children referred to them were boarder babies or were abandoned physically or emotionally; and the identified primary caregiver was the biological parent, foster parent, or kinship provider. In these settings, their work focused on addressing two very serious child welfare problems: boarder babies and abandoned infants.

Projects were given the flexibility to address the issues of infant abandonment according to the particular needs of their communities and to identify and implement effective and innovative ways of serving high risk families. Without this support, the ability to change and grow programmatically would never have occurred.

Vulnerable infants had to be placed somewhere, and the hospital setting was not suitable, unless they were medically compromised. AIA funded projects had considerable flexibility in how they addressed this situation. When the biological parent was likely to assume the caregiver role, even after initial separation, projects focused on keeping the children in their biological home. They did this by offering an array of multidisciplinary services (i.e., case management, substance abuse treatment, parenting support,

and child development follow-up) either directly or through referral to other agencies with which they were collaborating.

When, however, the child was separated from the parent because of local or state legal mandates (i.e., prenatal drug exposure considered child abuse) or because the mothers abandoned their children, reunification was generally not an option for AIA projects. AIA programmatic responses were dependent upon interagency collaborations with the legal, adoption, and child welfare systems, and with the medical community if the child was medically compromised. In any case, strong interagency collaborations were critical to ensure safe, permanent, and nurturing placements for the children.

Given the social and political changes that were occurring simultaneously in the nation during this period, the achievements of the AIA projects are noteworthy. AIA sites managed to weave welfare reform, Medicaid restrictions, the Adoption and Safe Families Act (ASFA) regulations, and federal-state budget balancing requirements into program design and implementation. Already financially stretched and facing the added challenge of serving drug affected families, each AIA site managed to not only work within the political and social service system, but also realized the need to impact programmatic and policy change on behalf of the children and families they served.

Located in every part of the country, serving a population of highly diversified and unique cultures and operating under different political and policy-driven conditions, AIA projects arrived at similar conclusions concerning work with these families. Although the projects began with their own set of ideas about

effective intervention, reaching out to the clients and engaging them meant that these ideas had to be realigned to fit their population. This was part of an important process for AIA called, “learning what works.” As it would happen, this was also the start of a new theoretical and programmatic foundation to address the full scope of needs of AIA children and families.

In many respects, the original group of grantees was pioneers in a new field. Charged with addressing the needs of abandoned infants and boarder babies, project staff drew from a variety of disciplines and philosophies to build their theoretical foundation. However, the fields of child development, maternal-child health, substance abuse, child welfare, and the legal/political communities often presented conflicting conceptual principles. Nonetheless, AIA projects learned over the years to mold these disparate theoretical bases to fit the specialized needs of AIA children and families.

Project sustainability is always on the minds of project administrators, and federally funded projects are particularly vulnerable to elimination. This small group of AIA projects has received continuous funding for over a decade, and most of them will receive funding through 2004. When they are on the receiving end of stable funding, project administrators are freed of the worry of having to identify basic fiscal support for the core elements of their project.

AIA projects also benefited from having consistency at the federal administrative level. This meant having the support of a single federal Project Officer who knew the design of the grantees’ projects from the onset, who shared in their programmatic struggles, and who advocated on their behalf over the years.

Even more remarkable, many of the original group of AIA project administrators maintained administrative oversight of these projects over the years. With few exceptions, the nine AIA project directors contributing to this monograph have been AIA administrators since 1990, and the rest were not far behind with AIA administrative experience of at least seven years. Additionally, the project director of the AIA National Resource Center has been associated with the project since initial funding. This phenomenon of program steadfastness in the social service field is not only unique; it appears to have contributed to common therapeutic experiences.

In parallel sequence, the Children’s Bureau supports AIA projects, AIA projects can therefore ensure availability to their families, who in turn learn to provide the same stability to their children. Under these conditions, AIA projects became a force for stability in the lives of families, who learned that project staff would be with them for the long haul.



Family Focus: A Promising Strategy for Serving High Risk Children

JEAN ADNOPOZ
JANICE CURRIER-EZEPCHICK

The mission of AIA projects is to ensure the permanency, safety, and well-being of HIV and/or drug affected children and the family unit is likely to be the primary focus of their interventions. This strategic approach marks a significant departure from more common practices involving substance using populations that often do not recognize the parental roles and responsibilities of drug involved women and their partners and presume that safe and adequate care of drug affected children is best accomplished by removing them from their parents and placing them in the care of others.

From their initial implementation in 1989, AIA projects have provided a range of services that are informed by principles and practice standards derived from the fields of child development, mental health, pediatrics, psychology, and social work and grounded in family systems and cognitive behavioral theory. Many of the AIA projects have been influenced by family preservation and wraparound services, two prevailing models of home and community-based care for families of children at high risk of placement because of impaired or inadequate parental functioning. Family preservation programs

are time-limited, relationship-based, family-focused, child-centered, flexible services that are available to families in their homes around the clock. They are designed to prevent unnecessary out-of-home placements or promote family reunification by assisting parents to address their own needs and those of their children (Adnopo, Grigsby & Nagler, 1991).

Wraparound services place the child in the context of the family and the child's broader social ecology. The model promotes the creation of interagency collaborations, community-based, advocacy-oriented systems of care and the expansion of parental decision-making and involvement to meet the multi-systemic needs of children with serious emotional disturbances (Woolston, Berkowitz, Schaefer, & Adnopo, 1997). Theoretically based on environmental ecology, wraparound services stress unconditional care, and assume that changes in the environment will foster changes that persist over time for children, families and communities (Burns, Schoenwald, Burchard Faw, & Santos, 2000). Wraparound is a strength-based process of intervention that values parental empowerment, culturally competent providers, and the use of natural supports to augment professional involvement. Outcomes are measured against goals established by the family.

AIA projects recognize each child's developmental imperative to be raised in families by consistent, caring adults, typically biological parents, able to create stable home environments that help the child feel unique, loved, valued, respected, and safe. However, significant numbers of children in the United States today are at risk of removal from their families or abandonment because of the inability of their parents to meet their needs. Addiction or serious, debilitating illness makes it impossible for some biological parents to be active, consistent, appropriate caregivers without intensive intervention and support. Rather than recommend that substance or HIV affected children be removed from their parents, AIA projects have been committed to providing the range of services necessary to maintain children in their own homes, improving the functional abilities of their families, and minimizing the possibility of out-of-home placement that may disrupt important family attachments. AIA services accept parents as they are and work in partnership with them to address their dependency and treatment needs and help them to build the sense of self-efficacy and competence that will form the basis for responsive and appropriate parenting.

Some HIV and/or substance affected children face the reality of losing their parents and other significant adults within their family networks. These children may be orphaned or abandoned in hospitals. AIA interventions support children to grieve the loss of their families and cope with the feelings of sadness, anger, and guilt that may be associated with the death of a parent or loved one. In addition, projects have assisted parents struggling with issues of death and dying to identify other adults willing to assume responsibility for meeting their children's needs for permanence. Some projects continue to provide serv-

ices and support to the new caregivers that might otherwise be unable to respond effectively to the complex issues that these children can present.

The Role of the Family

The adequately functioning family provides a safe and secure physical and psychological environment within which children can be nurtured, protected, and guided. The family is the means by which multi-generational beliefs, values, codes of behavior, information about the world and expectations for the future are transmitted (Adnopo, 2000). Solnit

IN THE CLIENT'S VOICE

"The program worked for me. I found myself in a loving, supportive, and educational environment. I had the time to bond with my child. I learned parenting skills that were crucial to my confidence and competences as a parent. The outstanding care my child was given there set a standard for me and the education I received enabled me to carry on that high standard of care. The gradual reunification process allowed me to accept my responsibilities in a calm way, so I was not too overwhelmed. The program also enabled me to truly focus on the most important business at hand, reunifying with my child. I found it to be a loving, healing place. And I have benefited greatly from the experience."

(1976) has described the family as “the bridge from the past to the future,” providing historical continuity and a sense of being rooted in time and place. As social beings, children benefit from being reared within the structure of their families with blood relatives who offer a sense of familial affinity and continuity.

The family sets limits and boundaries for children that monitor and control their behavior and help them in their attempts to master their emotions and keep their more aggressive impulses in check. The family provides support and comfort for children when life’s pressures and stresses overwhelm them and when they are hurt, frustrated, or ill. Provence (1979) has noted that a central function of families is the provision of support to family members to enable them to cope with “short-term crises and life transitions, as well as long-term challenges, stresses and privations.” The family helps to address the feelings of fear, helplessness, and despair that may affect children exposed to psychosocial adversity and other unfortunate circumstances. The “healthy” family communicates consistently to each child the feeling of being loved, respected and unique, which assists the child to construct a picture of him or herself as competent, worthy and valued. This process, which takes place over time, underscores the importance of long-term family stability and coherence. In this manner, the family makes it possible for the child to form the positive sense of self that is necessary to develop caring relationships with others and become a contributing family and community member (Adnopo, 1996). Substance and HIV affected children may be confronted by daily crises and challenges within the family structure that are not easily mediated by parents whose behaviors or physical illness are largely responsible for the child’s psychological distress.

Kinship Families

The most appropriate caregiving option for children whose biological parents are unable to provide active, consistent parenting, or those who have been orphaned by the disease, may be to identify members of the extended family willing to assume the role of supporting the child’s psychological, physical, and cognitive development. The introduction of a member of the child’s extended family or social network able to assume the role of a consistent, familiar parent surrogate may assist the child to master his feelings and cope with the reality of his situation. The child’s continuing involvement with relatives enables him to retain his familial ties and, in some cases in which the biological parents are alive but unable to be daily caregivers, responds to his need to continue to see them

Kinship or extended family care has played a significant role in the rearing of children, particularly African-American children, historically and is now considered an important means of maintaining all children at risk of placement within the context of their own multigenerational histories and culture. In 1998, of the approximately 500,000 children in the United States in foster home placements, one-third to one-half were estimated to be living with relatives. For children whose biological parents are unable to provide active, consistent parenting, the extended family may be best suited to support the development of family members, a role traditionally assumed by the nuclear family. The multiple functions that continue to be served by extended families include income support, child care and household assistance, in addition to intangible supports such as emotional support, counseling and social regulation (Scannapieco & Jackson, 1996).

Families providing kinship, adoptive or foster care have many of the same needs for support, assistance, and concrete services as biological families, although many service providers fail to respond to them adequately. A study of professional attitudes towards kinship foster care found that most child welfare workers had positive perceptions of the motivation and competence of kinship foster parents, but they believed that agencies needed to modify practice guidelines and policy to accommodate their needs. Most significantly, those surveyed recognized that placement in kinship foster care may offer an advantage in facilitating permanency for children (Beeman & Boisen, 1999).

In fact, extended family members, who may have lost a daughter, son, or sibling themselves, often share the grief and loss experienced by a child upon the death of a parent. Without assistance, the adults may be too involved in their own mourning to be able to respond to the child's needs for support and understanding. AIA service providers, however, have learned to be sensitive to the needs of all family members and to assist them to cope with their own grief reactions. Grandparents, aunts, and uncles need to feel supported in dealing with their feelings of losing someone close to them before they can offer comfort to the children for whom they have agreed to take responsibility.

Children's Needs for Permanency

It is within the family that the need of all children for consistent, nurturing relationships with the adults that care for them can best be met. A stable, dependable relationship with a "psychological" parent allows the child to move appropriately along the developmental continuum. Through the medium of this

relationship (a secure attachment), the child is able to satisfy his curiosity through safe exploration, learn to express himself, fuel his imagination and creativity, and gain trust in his world. From infancy through adolescence, the child seeks the approval of his primary caregivers as he approaches new tasks and confront new developmental, cognitive, and physical challenges. The necessary task of seeking independence, which is central to the developmental stages of toddlerhood and adolescence, requires the stable presence of an adult, family figure from which the child or adolescent can safely separate.

Multiple placements and severe disruptions in caregiving evoke feelings of loss and abandonment, deprive children of the consistent relationships that foster a sense of belonging, and threaten their ability to master age appropriate tasks. As a result, these children are likely to suffer from an inability to form

IN THE CLIENT'S VOICE

"They took care of my baby so excellent —the feeding, the massage and the exercises they showed me how to do with my baby —it helped me feel closer to the baby. And, the baby's going to my sister worked out fine for me too. He's with my family instead of in foster care only until I can get something more appropriate for both of us. I would recommend the program to other mothers who need good care for their baby until they can work it out."

positive attachments to other adults, experience high levels of anxiety and guilt, engage in displays of socially unacceptable behaviors or become depressed and even suicidal. Some children will act in ways that are dangerous to themselves and others out of their belief that no one will care. If no one cares, then behaviors, no matter how unacceptable, will not matter. The child whose basic needs are unmet, who is forced to endure multiple separations from his/her mother, who spends hours worrying about her whereabouts or her safety, and who assumes the role of protector and caretaker is diverted from his normative developmental tasks and at increased risk for poor psychological, as well as cognitive, outcomes.

The Needs of Parents

The ability of parents to respond to the changing needs of their children is strengthened by the support of others within the family, the extended family, and the community. Partners, grandparents, siblings, peers, and service providers play a role in giving parents the external validation and support they need to feel competent in their caregiving role, and to meet the challenges presented by active, developing children (Solnit, 1980). Erickson (1950) found that concentric circles of caregiving are essential for the support of children from infancy to adulthood. These circles of support extend from the helpless, dependent infant to their mothers, families, and the broader community. Child, family and the larger environment continually interact in a complex, biological and psychological process that helps families to shape the developmental outcomes for each child while also profoundly influencing the lives of all family members. The parent not only acts upon the child; s/he changes in the process.

AIA project staff members have noted the strong wish of most parents to be seen as competent and caring in the parental role. In fact, some mothers and many fathers have been labeled mistakenly as uncaring and neglectful when they do not visit their children in the hospital or fail to keep appointments. In actuality, their absence is rooted in their fear of authority and their inability to tolerate the disapproval and disdain they may receive from professionals who may view them stereotypically.

Many drug involved parents have histories of feeling marginalized and disrespected that have led them to be particularly sensitive to the actions and inferences of others in positions of power. Perhaps the most powerful of these are individuals who can influence whether or not children are removed from their care. Therefore, parents may actively withdraw or retreat from interactions with professionals, in defense against overwhelming feelings of helplessness and powerlessness. However, AIA projects have found that when parents are understood, accepted, and empowered, they are more likely to act in socially condoned ways.

The clinical issues that emerge in the treatment of drug using women are frequently related to earlier, unresolved traumas that continue to interfere with their ability to maintain healthy, intimate relationships with others. Women seeking treatment for substance abuse often report histories of physical and sexual abuse, frequently dating from early childhood. These women are likely to have had a series of partner relationships characterized by recurring episodes of domestic violence to which children were frequently exposed. When actively engaged in a long-term, therapeutic intervention, these women can be helped to disclose and confront their own issues of

abandonment, neglect, and victimization by others, often for the first time in their lives.

Sixty percent of female substance abusers have been estimated to have co-existing mental health disorders among which depression is the most common

IN THE CLIENT'S VOICE

"I had gotten pregnant and knew I needed help. I was on the streets with no place to go. I had heard of a place that will help women, especially women with children. So a woman can get her life back, along with the children's lives back. Luckily, they let me in. I was one of the fortunate ones. (The program) taught me structure. They had extensive therapy designed especially for women and women with children. They made treatment a family process instead of treating someone for 30 days then letting them go. We had parenting classes, budgeting, and cultural diversity classes. Also, we learned to work together as women, how to express our feelings in an appropriate manner, and how to be assertive. I would have died on the streets if it had not been for (the program). They will also be my family, and I will never be able to pay back what that facility has done for my family and me."

diagnosis (University of Tennessee, 2000). It is hypothesized that attempts to self-medicate depressive symptoms may serve as a precursor for drug use. These complex issues may affect the behavior of women who abuse substances while they are pregnant and as they attempt to parent their newborns. Fraiberg, Adelson, & Shapiro (1975) described the unresolved barriers to attachment and positive parenting as "ghosts in the nursery," visitors from the unremembered past.

Characteristics of Families Served by AIA Projects

The presence of substance abuse and/or HIV infection, although usually specific to individuals within a family, has serious implications for all family members. Parental addiction and HIV infection occur only rarely in isolation; they are more usually embedded within a constellation of factors that include poverty, racial and ethnic discrimination, joblessness, housing instability and constricted social networks that inhibit the ability of affected families to provide the stability and safety required for the healthy development of children. In addition to the pressure of their concrete needs, some parents may be burdened by feelings of guilt, shame, and ostracism related to their illness. Their inability to respond appropriately to the needs of their children and the social disapprobation of their lifestyles may heighten their feelings of inadequacy and victimization. For many substance involved or HIV infected parents, the natural or informal support systems that are necessary for effective family functioning have all but disappeared. Therefore, parents and children are isolated from their extended families and communities and the adults have few planned opportunities to be relieved of their parental responsibilities or to access support and information when it is needed.

Adults in families struggling with addiction and chronic illness are likely to display poor coping skills in all the domains of their lives and may have difficulty negotiating the interrelationships between themselves, their children, and the services and resources with which they must interact in the community. These families frequently present as disorganized and without structure. Their lifestyle of active addiction often results in a trail of burnt bridges and missed opportunities, while attempts to intervene positively in their lives are frequently rebuffed as unwanted or misunderstood as punitive societal responses to their condition. The secrecy and denial that families affected by HIV/AIDS often employ as a means of defending against rejection and negative interactions frequently lead to disconnection between family members, their needs and the mainstream resources that could help them and prevent their engagement in potentially useful traditional service systems (Adnopoz, Forsyth, & Nagler, 1994).

Children's responses to living in families affected by drugs and chronic illness are dependent upon their developmental stage, internal resources, and external supports. The literature identifies several stereotypical roles played by children living in chemically dependent families, including the "family hero", the "acting out child" who becomes a scapegoat, the "mascot or baby" who maintains the cheerfulness and jocularly of the family, or the withdrawn, socially isolated child who is often referred to as "the lost child." All of these roles represent developmental difficulties in attachment and separation-individuation. While these roles may begin as adaptive defenses to a dysfunctional family, they can soon become fixed in the child's character (Wegscheider, 1981; Black, 1981).

Parent/child role reversal is observed frequently in families headed by substance abusing parents. Mothers in recovery and their children describe desperate measures taken by children to prohibit parental drug use during times of active parental addiction. Some of the strategies reported include stealing the parent's money; attempting to block the door, physically preventing parents from leaving home; and following parents when they leave. Regaining parental authority can be a long and difficult process for recovering parents. Only when a parent has begun the work of recovery and has exercised her parental authority do children feel safe enough to display, through their behavior and attitudes, their own concerns, fears and vulnerabilities related to the substance abusing behaviors of their parents. Parents often find it difficult to understand why their children begin to have difficulties when they are in recovery. The pain of reliving the period of active addiction through their children's memories is often too difficult to bear. Consequently, without family-focused intervention, children may be denied the opportunity to have their feelings validated and to be assisted to recover from their parent's addiction.

AIA projects respond to these conditions by placing a strong emphasis on the process of engagement and relationship building not only with mothers but also with fathers, whose presence is often ignored or even discouraged by traditional treatment providers. Many drug involved or HIV infected women are conflicted about the multiple roles they have been expected to play. Some women describe a history of "over-responsibility" in which they were obligated to act as mothers, spouses or partners, daughters and sole family providers (National Evaluation Data and Technical Assistance Center, 1997), without adequate preparation or support. They may feel victimized by

IN THE CLIENT'S VOICE

"What I've found with (the program) is that they helped me as far as finding out who I am. The support groups with the other women, I mean, it was the best thing I ever did in my life. I, too, lived in a homeless shelter and I have five kids and I struggled for awhile staying off drugs and alcohol. I lost my children because of the drugs and the alcohol, and I have all my children back. And I have my own home—I'm not homeless anymore—and I have a job. And it's just one day at a time."

men and ambivalent about their presence in the household. At the same time, some fathers who play a significant role in the household are not included when decisions regarding the family are discussed and treatment planning takes place. Fathers and father surrogates play important roles in the lives of children; clinical experience has shown that each child yearns for an involved, accepting father who acknowledges and plays a role in his/her life, whether or not that father is available in reality. Yet children are often warned not to mention that fathers are active members of the family for fear that this knowledge will jeopardize the family's finances or worse still, the child's custodial relationships. The family must be defined as it defines itself; staff must not routinely exclude certain members. Enabling the family to name and involve its members honestly and openly helps to build the trusting relationships between family members and service providers that are essential to successful intervention.

Summary

It has been generally recognized...that the lack of essential foods, vitamins, etc., in early childhood will cause lasting bodily malformations in later years, even if harmful consequences are not immediately apparent. It is not generally recognized that the same is true for the mental development of the child. Whenever certain essential needs are not fulfilled, lasting psychological malformations will be the consequence. These essential elements are the need for personal attachment, for emotional stability and for permanency of educational influence (Freud & Burlingham, 1944).

AIA projects are built upon the presumption that the child's family is the most likely entity to provide the continuity of caregiving relationships, sense of safety, and consistent nurturing upon which healthy child development depends. A child's character, behavior, and functional status are determined by the interaction between each child's inner self, his biology, and his or her familial environment. For some children, the environment can be positive and health-promoting; for others it can be noxious and require either change or the removal of the child. Opportunities to work within the family, gain the trust and respect of family members, and support the family to mobilize its strengths in the interest of promoting the healthy development of its children have made it possible for many children at risk of placement to achieve permanency and stability within biological and kinship families. AIA projects have been committed to finding permanency for children affected by parental substance abuse or HIV disease; a consistent focus on working with families holds promise for meeting this goal.

Community Collaboration in Serving AIA Families

DONNA CARSON

The complex issues and needs of families affected by substance abuse and/or HIV bring multiple systems and agencies into the lives of the family and into contact with each other. These systems span many areas including law, health, mental health, child welfare, housing, school, and substance abuse treatment, and they present unique opportunities for collaborative efforts that can enhance services to families and reduce duplication of efforts. Recognition of the essential role of effective collaboration on behalf of the women, children, and families served by AIA projects, and an expectation by the Children's Bureau that such collaborative efforts would be a critical part of each project, was present from the inception of the program.

Each AIA project approached the development of collaborative efforts according to its own needs, opportunities, community resources, and location. Although the resources differed in each community, several important agencies and systems were routinely involved in the lives of the families served by the projects, regardless of the project site. The ability of the projects to develop effective and functional coordination of services by this network of agencies was critical in maximizing the efforts of each unit and in

making all of the systems better meet the complex needs of the families served.

Critical as it is, interagency collaboration was often very difficult to establish and maintain. AIA projects varied in how effectively they were able to promote

IN THE CLIENT'S VOICE

"I think the one thing I want to say is that one person can't raise a baby, and this program has been my community. The program and the people here have been her (child's) other parent. I came into the program homeless, too, no anything really, just pregnant and looking forward to a sweet baby. They've helped me with things I couldn't help myself with at that time. And, you know, the older (her baby) gets, the less dependent we are on (the program) and the more independent we're getting."

collaboration and establish formal interagency agreements. Politics, funding, personalities, and turf issues in agencies, governments, and between projects are realities that cannot be avoided when building coalitions that serve common populations. Collaboration requires agreement on mutual goals, as well as a commitment of the agencies to make cross-system coordination work. The commitment to a shared mission, identification of roles and expectations, effective communication, and identification of goals and objectives is a process that takes time, patience, and the willingness to take risks.

Most AIA projects have a primary relationship with a medical institution, frequently a public hospital.

These institutions historically have served the most vulnerable populations and are often a “safety net,” identifying and referring many families most in need of AIA services. Hospitals have been some of the most willing partners in the establishment of collaborative efforts and projects because they witnessed the costs and medical consequences associated with the lack of drug treatment and social services. Since hospitals were affected greatly by the boarding of infants, they have been involved with AIA projects from the beginning. They were eager to work in conjunction with other services on this problem that affected their finances as well as their staffing requirements (Zellman, Jacobson, DuPlessis, & DiMatteo, 1991). Also, the identification of pregnant and post-

PROJECT VIGNETTE

Project Prevent, an AIA project originally based at Grady Memorial Hospital in Atlanta benefited from strong collaboration with the medical system and linkages that were created between the medical system and other primary systems in the community. Although there was a very high incidence of substance abuse among pregnant women who utilized Grady Hospital for prenatal care and delivery services (approximately 20% of the delivery base), there was no established linkage between the hospital and substance abuse treatment services prior to the existence of Project Prevent. After the implementation of Project Prevent and the development of “partners” in serving pregnant woman, immediate success was realized by all: the hospital, the treatment centers, and the women. The treatment projects benefited by serving a greater number of women but also found that getting other needed medical care became easier because they had developed positive relationships between other systems. Rather than sending women who were ready for treatment out of the hospital with nowhere to go, the positive working relationships between the systems facilitated getting the bed space needed and assured the links to necessary medical follow-up. This was essential because the pregnancies were considered high risk and often required close medical monitoring. Bringing the systems together to identify the needs and barriers in serving the population resulted in creating strategies that reduced the barriers, increased the services, and provided a support system for the workers as well as for those served by the projects.

partum women in need of AIA services, as well as effective linkages to prenatal and obstetric care clinics, was essential. Although few of the original AIA projects were initially involved with pregnant women, most of the projects came to understand the necessity of preventive care for the pregnant woman and the fact that pregnancy can serve as a great motivator for change. Other components within the medical setting (e.g., specialized infectious disease clinics, family planning services) also provided services to women and children served by the AIA projects. Although medical care is offered at the hospital site, the lack of hospital outreach services prompted a very useful partnership between the AIA projects and the hospital or clinic. Follow-up on missed appointments and advocacy to bring the client to the needed medical appointments and negotiate often difficult systems had positive outcomes for all involved (Greenberg, 1996). Many of the hospitals that conduct drug screening were able to utilize the results to connect women to critical services offered by the AIA projects, resulting in greater medical compliance and an expansion of the hospital services. The families, who also present psychiatric, dental, and other complex medical problems, benefit from the coordination of efforts and the association between systems. Not only does this allow the hospital social worker to connect the woman to services and intervention, it also assures the medical staff that follow-up for the newborn infant will occur. The chronic lack of appropriate medical services for these clients and the barriers often presented by medical systems is addressed by partnerships between AIA projects and others.

Public health departments, and other systems that help identify and monitor the health needs of at risk families, have also been strong collaborative partners

of AIA projects. The expertise of the AIA projects in providing intensive home-based services with this population offers a rich resource for the outreach efforts of public health, and helps reduce some of the barriers that make follow-up care difficult.

Since many of the families affiliated with AIA projects are involved with Child Protective Services (CPS), a strong working relationship with this agency is essential. Whether the goals for the family are preservation, reunification, adoption, etc., a relationship with CPS is critical for effective work. Changes in welfare reform, which have added new expectations related to financial stability and access to services (American Bar Association, 1990), have made close communication between the AIA projects and CPS even more imperative. When positive relationships exist between AIA projects and CPS and goals are established that are acceptable to the family and shared by both systems, planned and coordinated services result. When these relationships have not been developed, the services can be fragmented and less than optimal. Relationships with CPS have been some of the most difficult to establish and maintain for AIA projects; several factors may account for this. State, county, and hospital reporting protocols for positive urine screens and other substance abuse issues shape the responses and expectations of CPS regarding drug treatment, child custody, support services, and inclusion of other providers on the service delivery team. In fact, great variation in reporting protocols exists between and within states, counties, and hospitals. In addition, occasional conflicts about treatment, relapse, safety, and placement of the children put the AIA staff and the CPS worker at odds and may leave the family unsure of expectations and distrustful. However, some AIA projects have been effective in establishing lines of communication with

CPS and have worked out agreements regarding expectations of the families, available resources, and support by each agency. This has eased the tension that exists when the systems are not working together and making mutual plans. Balancing the needs of the parents and children and the mandate of CPS requires on-going communication and adaptation to shifting community resources and political climates that often affect policy.

Two other partners critical to the work of the AIA projects are substance abuse treatment and mental health services. The high percentage of women who present with dual diagnosis, depression, and life-long issues of abuse, neglect, violence, and involvement

with the criminal justice system, is well established in all of the projects. Obtaining the services necessary to address these chronic problems is difficult and reflects the fragmentation of services that exists in most communities. In many locales, there are not adequate numbers of drug treatment slots available. In others, the treatment services may not provide for the needs of women with children, or for a woman who has a high risk pregnancy. Many of the treatment programs, especially those that require the woman to begin working within three months of entering treatment, are not, in that length of time, able to address the mental health needs of the woman or her children. Some of the AIA projects have added a mental health component in order to

PROJECT VIGNETTE

In Illinois, the Department of Children and Family Services (DCFS) worked collaboratively with a variety of community partners to create a family-focused continuum of services, an expansion of the traditional DCFS model. Supported by AIA funding and working in conjunction with the Cook County Hospital Women and Children's HIV Program and other providers, the AIA projects (First Love, Aban, and Family Options) provided outreach services, education, peer support, and other intensive home-based and family-centered services. The consortium attempts to prevent out-of-home placement, but also provides social work and legal services for families who need to make permanency plans for their children. The partnerships developed between these systems helped establish a support system for the workers, clarified values among the various projects, and brought to the table differing views of the family based on the role and boundaries of the worker. Cross training, respect for the roles of other agencies and workers, and enhanced communication have yielded a partnership that is ever changing yet beneficial to all. The time and energy that is required if these collaborative efforts are to be effective is significant and requires adjusting to new policies and changes in funding and personnel. However, the staff's ability to influence the larger systems and policies that affect the families is immense. They not only offer additional support to workers who often feel isolated, they bring a richer and more coordinated array of services to families and children by a group of professionals who are working together.

CLIENT VIGNETTE

A systems approach has been an integral part of the CIWI project located in New Havens, CT. Attempts have been made to bring together players from numerous systems through casework, as well as through broader systems work. Three important meetings bring the collaborators together on a regular basis. Each week, a triage meeting is held at Yale New Haven Hospital. This meeting, which primarily focuses on case identification and planning, is attended by medical and social work staff of the hospital, a home visiting nurse, a representative of a local drug treatment program for women, and a representative from child protective services (CPS). The CPS worker is the quality assurance person for the region and monitors the case planning for high risk newborns within her own system. A more focused case review is held bi-weekly at the CPS office. Led by a supervisor of a protective services unit, this meeting brings together CPS workers and the team providing services in the home. On a monthly basis, the Steering Committee of the project meets at the local CPS office to discuss program development, systems issues, and trends identified through the case work. Creative case solutions bring together these traditional collaborators as well as new collaborators. The following is a case example of how positive community relationships enabled providers to take a new approach to a severe domestic violence situation:

Susan W. and her five young children had been enduring the violent rages of Susan's boyfriend for years. She often sought help from one of the providers working with her family. Unfortunately due to Susan's cognitive limitations, her defensive anger, and her inability to articulate details of the case, the police and court system were unable to intervene effectively. The home-based AIA team met weekly with Susan and her children. Establishing trust was a lengthy process. Susan and her children were accustomed to feeling threatened and judged by the people who entered their lives. The team enabled the children to use art as a means to express their fears and anger towards the perpetrator. The drawings, along with the children's comments, were shared with the domestic violence advocates, CPS workers, representatives of the local Community Policing Program, and the detectives investigating the pending criminal charges. The graphic drawings so moved the providers that it assisted the team to maintain the focus on the effects of the violence on the children. The detectives became so motivated to address the problem that they were willing to try an innovative approach to the situation. A planning session was arranged to formulate a safety plan for the family anticipating the perpetrator's release from prison. The detectives agreed to visit him while he was in prison and inform him that a restraining order was in place and would be enforced. The same detectives visited the family to provide feedback about the safety plan and to make a connection with the family under positive circumstances. Ultimately, with all the providers remaining focused and in communication with each other, the perpetrator did not disturb the family again.

meet the needs of the women and children they serve better. Other projects have a representative from mental health services as a consortium partner and are better able to broker needed services. The availability of treatment options that meet the special needs of women, particularly women with children, is critical. As funding has dictated the development of outpatient treatment as the primary treatment option, many of the projects have found that even fewer mental health services are available to the women. Children's services are even more difficult to obtain; often AIA projects have had to provide these services directly when they are not otherwise available. Efforts must continue to assure that these vital services are an integral component of the service package made available to families.

The legal system, including juvenile court, probation, parole, jails, and the criminal justice system, is frequently involved in the lives of clients served by the AIA projects. This system often determines the availability of the woman to parent her children, the children's placement, family reunification, and the establishment of a case plan for the woman. Since many of the women's lives continue to be affected by the legal system because of past or current behaviors, collaborating with this system is critical. Rather than be viewed as adversarial, many AIA projects have developed complimentary relationships with the court. When working in conjunction with AIA projects, the legal system can be invaluable in dictating the provision of scarce services to the client. This system also can be responsive to the assessments and recommendations of the project staff. For instance, in states with mandated reporting of a drug positive baby, AIA projects work with the family to carry out court orders in an attempt to keep the family intact. Court mandates also provide leverage in helping

women, who were previously unwilling, to accept treatment. In turn, advocating for the women, securing appropriate treatment for them, and educating the courts and family members about addiction have made for increasingly strong relationships between AIA projects and the courts. A partnership with the legal system and courts has insured that the goals and expectations of the court are realistic, are understood by the family and service providers, and have the most optimal chance of being accomplished. Further, through collaboration with the legal system, some AIA projects have been instrumental in developing new state custody laws and guidelines.

Since the AIA projects address all of the families' life issues, many additional systems are critical to comprehensive service delivery. Relationships with housing, schools, employment and job training, nutrition, parenting, early intervention, and battered women's services are all critical to the provision of comprehensive services. Housing is recognized repeatedly as one of the biggest barriers facing the families served by the AIA projects. Many women recently released from treatment must return to their former drug-ridden communities due to the absence of drug free and affordable housing. In addition, financial limitations, criminal backgrounds, and large household size often make affordable and safe housing impossible for the women. These circumstances make the possibility of relapse a constant threat. Several AIA projects and communities, however, have been able to create new residential environments that offer the woman and her family better possibilities for sobriety and a new start.

Collaborative efforts with other systems vary among AIA projects and have been directly influenced by differences in community politics, resources, and

PROJECT VIGNETTE

The TIES project in Kansas City, MO, as part of a larger task force serving drug-exposed infants and their families, participated in the design and implementation of a transitional housing program for recovering women and their children. The housing committee helped establish an eight-unit apartment building for women and children that included mental health services. The program obtained non-profit status and is guided by a board of directors representing the original participating agencies: drug treatment, child welfare, family court, child care, health care, and emergency assistance.

personalities. Many of the AIA projects formed Advisory Boards that were comprised of high level administrators within the various systems who met on a regular basis to discuss the needs of the families and collaboration among the agencies. In addition, many AIA projects were part of task forces or coalitions that were based either in their own agency, or within their city, county, or state. The task forces had many functions including: educating legislators and

policy makers; developing area-wide plans for addressing the needs of families; coordinating area-wide services; increasing availability and access to drug treatment and related services; improving obstetric and pediatric outcomes; providing primary care; and decreasing prenatal drug use. Moreover, many task forces researched available resources and collected data prior to developing functional collaborative models. In all circumstances, the firm commit-

PROJECT VIGNETTE

Los Pasos at the University of New Mexico (UNM) funded a family preservation worker who attended interdisciplinary meetings between the UNM Department of Pediatrics and the New Mexico Children, Youth and Families Department. These meetings proved to be highly effective at enhancing the referral process, addressing systematic problems, and facilitating discussion of the most difficult cases at a higher administrative level. This sound working relationship enabled the family preservation worker to provide services to high risk families without a referral for child abuse/neglect and to extend the length of service. The project subsequently expanded to two family preservation workers, whose salaries were assumed by the Department of Children, Youth, and Families.

ment of the agencies and the agency representatives was of paramount importance. Value clarification, an understanding of roles, and training were necessary to establish a strong working foundation. This is a continual process and one that is maintained by the commitment of the agencies and the individuals who participate and their strong belief that their collective efforts can improve all of their individual efforts. Some common tools used in the development of these relationships by the AIA projects include using coalitions to expand the staff and resources of the project; co-locating the project or some of its services; and providing services in a cluster (i.e., one-stop shopping). Additionally, several AIA projects funded positions that were placed within other agencies.

The collaborative efforts of the AIA projects have involved independent agencies, as well as statewide systems, since all affect the quality of services that are available to the families and their children. Several AIA projects have provided testimony to their state legislatures on issues related to the prevention of child abuse and neglect, as well as treatment issues that affect the women and families served. Media coverage of some AIA projects have resulted in public discussion and awareness of the lack of adequate resources, particularly treatment, for the women served and the precarious state of child protection in many of the communities served. Heightened awareness, resolution of many barriers to care and obstacles to family functioning, and an increased expectation of accountability of the public agencies have resulted from these collaborative efforts.

All of the AIA projects have a strong commitment to establish effective collaborative efforts within their communities. However, the difficulties encountered are numerous and require skilled negotiation and

patience on the part of all participants (Hines, 1991). Turf issues and unstable funding are a constant barrier to serving the best interest of the families. Projects that were once significant players in the collaborative effort may lose their funding and leave a void in essential services for families. Often the AIA projects, because of their flexibility in operations and expertise at developing programs responsive to the needs of families, are able to adapt services to changing needs and to alter approaches when it appears indicated. This is not usually the case with the larger systems, which are bound by more fixed procedures and protocols (Winer & Ray, 1994). Changes in large, established organizations may take years to happen, if it happens at all.

The effectiveness of collaborative efforts also is greatly influenced by political changes, both locally and nationally. Appointment of new judges and changes in Medicaid funding and treatment services all determine the issues that must be tackled, as well as the risk involved in tackling them. When new programs begin in communities, particularly grant funded projects, they must quickly “sell” their project to various groups in order to sustain it. This often reduces the time they have to work toward effective collaborative efforts, as well as the development and implementation of their own project. It also renders an existing consortium indifferent to participation by a program that may not be around for long. The issues presented by the families are complex and the systems from which they require services and cooperative efforts are no simpler.

PROJECT VIGNETTE

The TIES project joined a multidisciplinary task force serving drug exposed infants and their families when they received their initial federal grant. This task force comprised of physicians, health care providers, social workers, child protection staff, court personnel, drug treatment providers, educators, and early childhood personnel, problem solves issues that affect infants born to drug using mothers. It serves as a vehicle for the recognition of needs and the coordination of efforts. The group has explored problems and issues that relate to drug involved pregnant women such as medical noncompliance, interpretation of child protection standards, case management of the family, and the state's role in supervision and custody of the children. The focus of their action is preventing barriers that keep the women from getting treatment and securing the protection and medical care of infants who are born to drug involved women. The task force has achieved many accomplishments including: obtaining funding for family aides to provide in-home assistance to high risk mothers; securing funding from the Center for Substance Abuse Prevention for outreach services; identifying youth at risk of endangerment or neglect due to a substance using caregiver; establishing hospital guidelines for a multi-disciplinary approach to drug exposed infants; services for grandparents; and a housing committee. The establishment of a family drug court also resulted from the work of this collaborative team. The legislative arm of the consortium has been involved with issues such as treatment availability for pregnant women, protection of women, children's drug treatment from Medicaid managed care cuts, and issues that affect relative caregivers. The TIES consortium also assisted with the passage of the Grandparents as Guardians legislation that provides foster care reimbursement to grandparents and other relative caregivers who have completed training. Finally, the consortium advocated for the passage of a prenatal substance abuse bill, requiring state funded drug and alcohol programs to give priority to pregnant women, and requiring all physicians to conduct substance abuse assessments and education with all pregnant women.



Development of Successful Treatment Interventions

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AI A projects strongly uphold individualized, holistic services. In contrast to a traditional service approach that assumes a deficit model of human development, AIA projects recognize that family strengths are pivotal to the working relationship. Interventions are created in partnership with AIA families and are implemented at a variety of levels. Projects maintain a focus on the concurrent needs of parents and children, recognizing that attempts to intervene effectively with children will be unsuccessful if their family and social environments remain unchanged. The basic framework is a systems approach in which families are encouraged to define their strengths and their needs in the context of their total environment. Family-centered services and strong community level collaboration provide a solid foundation for the design of interventions to address child, family, and community development. Key to this process is a long-term, trusting, nonjudgmental relationship between the family and the AIA staff team. While all the pieces must be available for the multi-layered intervention ultimately employed, engagement with the family must be accomplished first.

This chapter will detail specific strategies used by AIA projects to engage families in comprehensive planning for themselves in order to promote safety, permanence, and well-being for their children. The elements common to the diverse AIA projects will be discussed.

Building the Relationship

A major programmatic emphasis for AIA projects is establishing and building trust with their clients. Multiply challenged families have frequently experienced failure with human service agencies, and they often have an expectation of that trend continuing. They have found themselves categorized as “non-compliant” or “resistant” or have simply been discharged from programs in the past related to perceptions of their behavior. AIA staff must realize the trust issues many families bring to the relationship and be willing to prove themselves and their value to the family before engagement can be accomplished.

IN THE CLIENT'S VOICE

"They are always there for you. I can always leave a message and someone will always call me back."

A successful relationship cannot be built upon a pre-fabricated set of activities or goals imposed on families. The family must come to view the AIA team as a partner who is willing to address the whole range of strengths it possesses and challenges it faces. The trust that develops between AIA staff and clients brings about an understanding of the family members' life struggles and carries a respect for their fears, values, and priorities. In other words, it is a relationship built on working *with* caregivers, not *for* them, and recognizes that the relationship caregivers have with their children is special and must be respected. Families are considered capable of making decisions for themselves and their children. In this regard, families are empowered and respected, since the family drives the direction for success. At the same time, projects do not leave the family adrift in the process, but support them in their decision-making. Highly skilled, culturally competent, nonjudgmental staff assist families in developing realistic, flexible plans and model an ongoing process of goal setting and problem solving.

It is helpful to see what other fields were saying about relationships during this discovery period for AIA projects. A corresponding movement in child development addresses parallel processes that occur in ideal clinical work with caregivers and children (Fenichel, 1991; Campbell, Nellie, & Gray, 1999).

This model looks at the mutual competence of supervisor-provider relationships, provider-caregiver relationships, and caregiver-child relationships, moving all three from "caretaking" to "nurturing" stages under optimal conditions. It is explained this way: when it is effective, the supervisor recognizes the provider as the expert of family functioning, the provider recognizes the caregiver as the expert in understanding her baby, and the caregiver takes her caregiving cues from her baby. In much the same way, AIA project staff learned that a system of mutual respect was critical in their work with families.

IN THE CLIENT'S VOICE

"I have a wonderful counselor, and I love her to death. There is nothing that I didn't feel like I could tell her. She's helped me through a lot of trying times."

Learning to listen to families was often a long, difficult process, frequently interrupted by the family's day-to-day crises, addiction, or relapse. Accepting the expertise of the family was at times very difficult for project providers, especially when child safety was considered a potential risk. A provider's job often involved creating a supportive environment for the family, in contrast to the typical chaotic physical and social environment. Project administrators recognized that front line staff, whether licensed or unlicensed, had insights that only first-hand interaction with families allowed.

Each project learned how to balance respect for the caregiver as the expert and continuous assessment of child safety. At times, this meant collaborating with the family in making a referral to a child protection agency, or discussing the reasons for a potential referral with them, so that the respect between them was not broken. At other times, this was not possible and the referral was made without family input. The bottom line for AIA has always been ensuring child safety.

In the day-to-day work with AIA clients, projects learned that individuals affected by HIV or substance use are not solely focused on one issue. Staff learned to examine the multiplicity of issues faced by clients and to take their direction from the family in prioritizing goals. Each project found that the complexity of clients' needs demanded broader therapeutic efforts, and a more holistic approach that addressed psychosocial and physical conditions as well as the client's spiritual life. At the same time, goals had to be built on existing family and community ties.

AIA projects also looked to the client as an agent of programmatic change. In the early years, AIA adopted a programmatic focus of short-term client involvement. However, AIA projects assumed a practice of long-term involvement upon the discovery that it supported the engagement process and addressed the needs and solutions of families more effectively.

Service Delivery Models and Approaches

AI A projects adopted a mix of service approaches to respond to the specialized needs and circumstances of client families.

IN THE CLIENT'S VOICE

"Reality hit very hard when (my baby) was diagnosed positive for drugs at birth and (CPS) stepped into my life. Then I met with this extraordinary lady who has been my shoulder to cry on, my Ann Landers for advice, my best friend I can count on for being there for me and my family. She has seen me through my family troubles as well as the accomplishment of moving on with my life. When I met her, like I said, I was reluctant. But one thing she did for me was not to PUSH! herself or the program on me. It wasn't till the most darkest of days, alone, that I recalled her and the program. So I picked up the phone and called her. She was there and has been here for me 100 percent, to brighten the darkest of days, ever since then. I feel lucky, thankful, and very blessed that she has been part of my life. Today I have grown a little more because she has shared. Like my S.O. says, "(Worker) is part of our family, which we feel very privileged and honored to have! I've been able to exchange ideas, life experiences, problem solving and just good old cries and pain with. I will have treasured memories I will never forget."

Multi/interdisciplinary teamwork

If no one project can be all things to a family, it is equally true that no single discipline can shoulder this responsibility independently. The diverse needs of AIA families (e.g., medical and behavioral health, social support, developmental services, and legal assistance) require the knowledge and skills no single profession can provide. AIA projects readily adopted the practice of multidisciplinary and interdisciplinary teamwork.

With multidisciplinary work, each team member values the input from other disciplines but presents assessments, makes recommendations for services, and provides intervention independently. With interdisciplinary work, team members assume leadership in presenting their viewpoints and in sharing responsibility for the case, but reach beyond their own perspectives and training to embrace what others on the team have to offer. Team meetings are held to develop a single service plan based upon the goals developed by the individual disciplines.

The key to working together is accepting that compromise is required in the process and that sometimes professional practice may indicate that

IN THE CLIENT'S VOICE

"My experience with (AIA program) has helped me to create a support network. With my worker, I have found lasting friendship that she expresses by visiting me at home."

additional training or group process work must be completed before a true working collaboration can be forged. Confidentiality, as ethically understood by the various disciplines, is one of the issues that plague many teams. At a project level, supervisory tasks mandate the clarification of client confidentiality when discussing cases within an agency. For example, because of the considerable legal needs of children and families, several AIA projects include lawyers or their representatives on the teams. What information a lawyer holds as confidential may not be perceived by other team members as confidential. It becomes critical to recognize this difference when working together on behalf of families. This stretches everyone's understanding of how to help families while learning to respect one another's point of view. AIA families are the ultimate winners in this type of collaborative relationship, since it has the potential for expanding the range of services families receive.

IN THE CLIENT'S VOICE

"Just knowing someone was there and coming (to the home), that kept me clean too."

Home visiting

Most AIA projects have implemented home visiting as part of their service component, including several that began as center-based projects. Home visiting evolved in response to clients who were either unable to participate in project activities because of inadequate or a lack of childcare and transportation, or found it difficult to comply with project

CLIENT VIGNETTE

Shari, a 35-year-old Caucasian woman, was referred for home-based AIA supportive services with the CIWI program in New Haven, CT, when she was pregnant with her fifth child. At that time, she was actively parenting two children, ages six and four; two older children had been placed permanently with relatives. Shari's mother was an alcoholic who was often absent from home. Sexually abused by an older brother at age ten, Shari was placed eventually in a residential treatment program for acting out, defiant behaviors at home, and truancy from school. At the age of 22, while actively using substances, she became pregnant with her first child. Shari has suffered from depression since adolescence. She describes these episodes as "sinking into a black hole." Although Shari was treated for depression episodically, she was unable to remain abstinent long enough to adequately address her disorder. In fact, Shari and her partner, the father of her three youngest children, continue to struggle with their addictions to crack cocaine.

From the start of the AIA intervention, the clinician and family support worker were never certain what they would find at each home visit. On one occasion, the apartment would be clean and organized, and the children would be playing with their toys quietly and contentedly. On the next, the apartment would be disheveled and disorganized. The boys would be out of control and playing aggressively. On one visit, the older boy threw a toy metal truck at a member of the team to divert attention from an adult conversation that he found troubling. Although Shari was capable of using appropriate parenting techniques and strategies, she did so unpredictably and infrequently. At each weekly visit, she reported a new crisis. There were shut off notices from utility companies, angry disagreements with extended family members, missed court dates, and fights between Shari and her partner. The team felt that working with Shari was like watching someone who kept busy putting out small brush fires but never recognized that she was responsible for igniting them.

An important goal of the intervention was to raise the parents' awareness of how their substance abuse and resultant lifestyle was affecting the children. In family sessions, the team built on the strengths of each partner to address the physical and emotional needs of the children. It was difficult for Shari to acknowledge the level of disorganization and chaos in her home. She felt that she was a much better mother for her children than her mother had been for her. The children's father, who had a more stable childhood, was able to demonstrate that he could provide additional structure in the home. With the support of the team, the father was encouraged to take on many of the responsibilities for his family. He gained self-respect and satisfaction from his accomplishments. At termination, both boys were doing better and they were in a special educational program. Both parents had entered drug treatment.

requirements. Rather than discharging them from the project, AIA staff began going to their homes, and was persistent in this activity, even if the family was not home or did not answer the door. By doing this repeatedly, AIA staff demonstrated a “show-of-faith” in their clients that broke the barrier of mistrust. Literally and figuratively, families were met and accepted where they were. This amounted to a somewhat radical approach to serving a group considered to be dangerous, drug using, and high risk individuals. It challenged the health care delivery system and the substance abuse treatment system, both of which expected clients to come to their offices for services.

By using the home as the primary site for service delivery, clinicians and other staff members are able to enter directly into the family’s environment and gain a richer understanding of the child’s world than is available in more traditional treatment settings. The willingness to go to the family’s home conveys acceptance, promotes the process of engagement, and supports the development of the therapeutic alliance that is essential to bringing about behavioral change. The experience of the AIA projects supports these assumptions and testifies to the capacity of parents, even those beset by severe psychosocial and physical adversity, to mobilize on behalf of their children’s health and development with clinically informed and appropriate intervention and assistance. AIA projects have found that sustained, non-judgmental, relationship-based, in-home services offer an effective intervention for families in which children would otherwise be abandoned or at high risk of losing their parents. Both children and parents have been assisted to return to more healthy lifestyles because of this approach.

IN THE CLIENT’S VOICE

“We have all had babies that have been exposed to drugs. CPS has entered our lives. We were told to enter a treatment center, we were told of a special program. At first, I think that all of us felt we had enough people in our lives. Each one of us entered the program for our own reasons. The program helped us with lots of things, such as diapers, food for the babies, rides to the doctors. They also help us with our problems in everyday life. They are there when we need someone to talk to.”

Solution focused

AIA projects recognize that families often face myriad issues with which they need concrete assistance. It was recognized quickly that families did not have the luxury of long-term goal planning when faced with multiple crises. The AIA approach is a solution-focused, problem solving one. For example, projects use funds flexibly to meet identified needs that may include such items as baby supplies, diapers, formula, or developmental toys. It may also involve food purchase for the family or helping to secure birth certificates or other required identification. It may even mean assistance with rental costs, utility assistance, or payment for childcare or prescribed medication. Underlying this assistance is the ever-present need for transportation. The provision of transportation by project staff has been discovered to have intrinsic value. Not only is it required in order to secure

PROJECT VIGNETTE

The Los Pasos and GRO projects in Albuquerque, NM use solution-focused intervention, developed by Insoo K. Berg (1994) and Steve de Shazer (1985) as a brief therapy model. It is an effective treatment approach with high risk families, particularly those affected by prenatal substance use. This short-term intervention allows the clients to participate in developing and implementing their treatment plans. Therapeutic interventions are focused on the future and on establishing a solution rather than focusing on the clients past self-defeating behaviors. By focusing on the competencies that families bring to therapeutic relationships, staff at all levels (i.e., case managers, social workers, developmental specialists, program administrators) use solution-focused techniques in these projects as a means of empowering families (and staff) to make positive changes in their lives. The approach uses a person's strengths, resources, and abilities as a base from which to build successes. It makes no assumptions about the nature of the "problems" that individuals who use drugs or alcohol might experience. Rather, it considers the person's particular complaint and works with the individual to find solutions. By taking this position, the staff member relinquishes the role of "expert" and enters into a relationship that is based on mutual respect, collaboration, and cooperation, making the client a partner in decision-making and goal setting activities. Ultimately, this reduces client resistance as individuals experience competency and increased control over their lives.

Los Pasos and GRO recognize the client's ability to change as the most powerful feature of this approach. This derives from the basic assumptions of solution-focused interventions: (1) change is constant and inevitable; (2) change comes from many sources and directions; (3) small changes lead to big changes; (4) it is more helpful to recognize a solution than it is to understand the causes of a problem; and (5) individuals have the resources and are the experts in solving their problems.

This approach is less about therapy and more about relationship building. Los Pasos and GRO have found that families are more likely to stay engaged in program activities when solution-focused techniques are used, and the more they are engaged, the better their outcomes. As one provider has indicated, when families are successful in meeting basic goals, it becomes easier to move them forward to tackle other goals for their children and themselves.

needed services, but it also seems to be therapeutic. The staff person's willingness to provide transportation personally, often in his or her vehicle, promotes the relationship and provides a safe, contained, confidential space for discussion of difficult issues that might not occur otherwise.

Residential projects

While nearly all of the AIA projects engage in home-based intervention, a few of them offer transitional housing for children or residential drug treatment for women and their children.

Common AIA Services

As strengths-based, individualized partnerships with families are common to all AIA projects, so are a number of specific interventions. The multiple benefits of home-based work have been noted. The importance of solid community-based collaboration has been detailed. The pivotal role played by initial and ongoing engagement is crucial. With the substantial degree of flexibility afforded AIA projects in their development, the number of themes common to all is telling. Common services are offered here

PROJECT VIGNETTE

MY HOUSE, associated with Project Prevent, is a transitional home for boarder babies in Atlanta. At Grady Memorial Hospital from 1991 to 1999 over 250 babies boarded in the neonatal intensive care nursery (NICU) for more than 4500 days at a cost of over seven million dollars. In order to develop an alternative to the costly boarding of these medically fragile infants due to lack of appropriate caretakers, Project Prevent developed a new component in June of 1999 called MY HOUSE. This unique facility is licensed by the state as an emergency shelter for medically fragile infants (ages 0-4) and provides a home-like setting where the medical and developmental needs of these infants can be met while awaiting permanency plans to be finalized. MY HOUSE cares for eleven infants and works closely with the NICU staff in order to place those infants who would otherwise board in this facility. Since many of these infants had prolonged medical courses, their medical needs are often quite extensive and follow-up demands are enormous. The facility allows the infant to stabilize to the point that their medical care can be more reasonably accomplished in a more traditional placement. Since it opened, MY HOUSE has helped reduce the number of boarder days at Grady and other hospitals, as well as boarder cost. It has been developed as a model that could be replicated in other communities that are dealing with a similar lack of placement resources. Since many of the children placed at MY HOUSE are entering adoptive placement, the project is also becoming licensed as a foster/adopt agency, which will help expedite the placement of the children into permanent homes. Some of the children are also transitioned into a variety of permanent placements, including with relatives, fathers, and out of state placements.

with a discussion of their implementation in specific AIA projects.

Comprehensive assessment

AIA projects use a variety of assessments to identify community and family needs. These include community needs assessments and gap analyses, infant and child development evaluation, risk identification, mental health assessments, and social support and parenting scales. Each project assesses community and family strengths and resources, as well as challenges and risks to child well-being. Projects take up

to three months to complete the assessment process in order to improve the quality of information and goal setting. The development of an intervention strategy is also influenced by the commitment to long-term intervention and engagement with the family.

AIA projects have found that a careful assessment of the father is meaningful to the child and the family. The nature of the father's interactions with the family informs treatment planning and is respectful of the child's important attachments. In addition, the work-

PROJECT VIGNETTE

Great Starts, in Knoxville, Tennessee, is a therapeutic community model of drug and alcohol treatment. In operation since 1991, Great Starts recognized how difficult it was to provide drug and alcohol treatment to families by the traditional methods. While no single form of treatment is effective for every drug dependent individual, a biopsychosocial perspective may be more suitable for women. This model accounts for the interaction between biological, psychological, and social forces.

Aware that some women would not seek treatment because they would not leave their children, Great Starts developed a "one-stop shopping" transitional living facility to enable pregnant and postpartum mothers to seek intensive treatment while their drug exposed children received early intervention services. Onsite childcare was developed for children to attend while their parents were in treatment. Drug education, child, individual, and family therapy, connection to AA/NA support services were developed to alleviate barriers to promoting successful recovering lifestyles. Addicted women and their children reside in transitional apartment dwellings for six months. They receive therapeutic, educational, and supportive services while residing in a safe, drug free, therapeutic community. A strong aftercare component is also provided, as well as crisis intervention and long-term family therapy. Significant outcomes of this project include over 60% of the clients successfully completing the treatment phase of the project and over 80% of children remaining in parental custody for an 18-month period.

er can help a woman identify the strengths and challenges of her partner relationship(s), and better determine her goals for each.

This comprehensive assessment process is ongoing and directly solicits families' perspectives. From this assessment process, the family-centered goal setting that is at the core of the intervention emerges. This approach requires balancing of competing needs – the needs of communities with the needs of individ-

ual families, and the needs of parents with the needs of their children. As a guiding principle, however, when competing needs cannot be reconciled, children's need for safety is paramount.

Care coordination/case management

Case management works as a powerful therapeutic tool in AIA projects. Projects provide this service to clients based upon the assumption that the families face multiple service needs that they are unable to

PROJECT VIGNETTE

The Family Centered Services' Home Visitation Program in Philadelphia, PA provides an example of comprehensive assessment. The client enrollment process takes place during the first four weeks of home visits. During the first visit, the social worker and home visitor establish a rapport with the family and describe the program activities. During the second visit, home visitors secure and review the following documents: medical records release, emergency contact forms, disclosure forms, and parent consents. During the third visit, families identify their own and their children's strengths and needs, using a standardized tool. During week four, the home visitor and social worker meet with the family to finalize the enrollment process and to develop the comprehensive service plan, which describes how the family and team will work together to achieve program and family goals.

Initial screenings are completed within 45 days of enrollment and include sensory (hearing and vision), developmental, behavioral, nutritional, health and psychosocial (strengths and needs) assessments. The home visitor/social worker team presents the results of this initial assessment and planning process to the full multidisciplinary team. Based on their assessed level of need and the services they require, families are then assigned to an appropriate "level of care." Those at the lowest level of risk and need (Level 1) receive a minimum of four contacts a month, including at least two home visits. Those at the highest level of risk and need (Level 3) receive a minimum of six to eight contacts a month, including at least four home visits. Assessment continues throughout families' involvement with the program, and levels of care are adjusted, as necessary, to respond to changes in family circumstances.

IN THE CLIENT'S VOICE

"They will help you with housing when ready and any kind of resources available. There's resources you probably didn't even know you had. There's always someone to listen to your problems. If they cant help you, you can bet that they'll find someone who can."

address on their own. The family is engaged in both identifying and meeting its own goals, so that the traditional case management approach of simply arranging services is expanded significantly. The case coordinator assists families in developing their goals, identifying their needs, and obtaining these services.

It is important to keep all matters on the table for intervention and to establish realistic timetables. So, while AIA projects provide a substantial variety of services directly, advocacy with other systems is also needed. Interdisciplinary work and multi-agency collaboration is the norm in AIA projects. This advocacy works on all levels: on behalf of individual families, on addressing the needs of the target population, and on working to coordinate all human services in our communities. Thus, the AIA projects strive to coordinate their own services and to advocate for, and integrate into comprehensive plans, the services of other systems as well.

Once services are secured, ongoing interdisciplinary, multi-agency communication is essential. AIA staff often coordinates this. In some cases, families may have multiple professionals identified as "case

managers" or some similar title. It is important to keep all the agencies linked to each other and connected to the family. Services must fit together and agencies must not be pursuing contradictory goals or asking families to participate in conflicting activities. For a family that may have a protective service worker, an income maintenance worker, a drug treatment professional, a probation officer, and a mental health counselor, this can be a big job! The AIA professional is often in the role of broker and negotiator in keeping each service abreast of the activities of others and insuring that the family's goals are being voiced and pursued by all.

Child development support

AIA projects work with family units, yet they never lose sight that these efforts support and enhance the child's development, well-being, and safety. Optimal child development hinges upon many factors and children with prenatal drug exposure are more likely to be at risk due to a number of confounding variables in their lives that include abuse and/or neglect, poverty, homelessness, HIV/AIDS, domestic violence, and/or mental illness. AIA projects deem it

IN THE CLIENT'S VOICE

"They worked with my babies and me by teaching me how to exercise them. And they taught me infant massage. They were great about that and that's helped them out too. So, it wasn't like I had to join (the program), but at the same I figured it would help me as much as my babies."

critical that everyone on the team assumes the responsibility for ongoing monitoring of the child and addressing any of the potential risk factors that may hinder the child's growth and development. For these reasons, AIA projects frequently include developmental and early childhood specialists as part of the interdisciplinary team to assist and guide families in the area of parenting and to offer developmental monitoring for the children. This monitoring may include specialized care for infants identified with specific needs at birth; infant or child screenings/assessments (e.g., Bayley Scales of Infant Development II) infant massage (provided by a specialist or by a trained parent); and referrals to therapeutic early intervention services or other projects

(e.g., Early Head Start). Although a developmental specialist is the ideal staff member to provide these activities, many of them can be provided by other members of the team, such as the case manager or the paraprofessional.

Parenting support

Although women served by AIA projects have been expected to assume responsibility for caring for their children and families, many were not adequately parented as children themselves. They lacked the opportunity to learn appropriate caregiving skills in their families of origin where their own needs for support, approval, and consistent nurturing may have been unmet. Therefore, it is unlikely that they will be able

PROJECT VIGNETTE

Project Aban in Chicago, IL provides parenting education to enhance family functioning. The Nurturing Parent classes are presented in eight-week sessions of one and one half-hours each. Each eight-week session is different, allowing women and their children to complete more than one session. The Nurturing Parent facilitator is a former teen parent who went back to school and became a pediatric nurse. She relates well to the client population being served.

Parenting is a complex process that calls for both analytical and interpersonal skills. Parents can use help developing the coping skills to improve situations that create stress in their family life. The Nurturing Parenting concept encourages parents to look at themselves, and their relationships with their children and other family members, and provides methods for them to find ways of nurturing themselves and addressing their own needs. Nurturing Parenting supports the use of nonviolent methods of discipline and provides child development information and skills that parents can use to enhance their children's growth. Through Nurturing Parenting education, the relationship between parent and child can deepen and grow, enhancing family stability and minimizing the possibility of abuse, neglect, and abandonment.

to attend to the needs of their children until their own needs are assessed and addressed through intervention.

Family support

A persistent and consistent approach with a family promotes a discovery of its power. AIA staff members offer unconditional positive regard in combination with a commitment to honest interaction. Over time, families can be convinced that service providers are genuinely interested in their goals for themselves and developing plans to reach those goals. At the same time, providers must be honest about their own priorities, particularly around child safety and permanence. The AIA staff can offer options, predict potential consequences of actions, and assist families in developing specific plans to accomplish identified goals.

As families experience their power and build some success, it is important to provide opportunities to

IN THE CLIENT'S VOICE

"The program helped me learn to respect myself and my body . . . I've got my kids back. I've learned boundaries. I'm living life, not just surviving. I've become a real mom and a real daughter. I also have learned that it's not okay for men to use my body or beat me. I've learned responsibilities (for) myself and my kids. I've learned to be a real parent with real parenting skills."

"give back." Families may want to give to the project, to other participants, to other recovering people or to AIA staff. As families express this natural desire, they can be assisted to develop safe parameters for their helping, serving as a model for boundary setting and decision-making in the future.

The special relationship that develops over time can create a safe environment in which to broach difficult topics. For example, families are encouraged to develop birth control plans so that pregnancies are desired and planned. Women may be assisted to deal

IN THE CLIENT'S VOICE

"At (the program) I can learn how to be a parent to my children, learn some value(s). Be able to spend my money and manage it better, learn how to deal with disappointment that will come in my life and not turn to drug(s). Be able to socialize with people and build up my self-esteem and love and respect other(s) as I will have them respect me. To me, (the Program) mean(s) to be able to survive out there in the real world being drug free."

with previous trauma including sexual assault and other domestic violence. They may decide to address sexual orientation issues that have not been dealt with. Counseling may be provided directly by the AIA project or may be secured from other mental health professionals. For some families, an environment is created where the discussion of whether or

CLIENT VIGNETTE

Jeanette, a 28 year-old African American mother of two, was referred for AIA in-home services after making a request for treatment for her drug addiction of 15 years while pregnant with her second child. Jeanette met Steve's father when she was a teenager. Anger and discord, witnessed by their son, marked their relationship. Following their separation, Jeanette became pregnant with her second child as a result of a rape. Her live-in boyfriend at that time, an alcoholic, agreed to raise the infant as his own. Motivated by the effects her drug use was having on her first child, Jeanette decided to seek drug treatment before her second child was born.

Her older boy, Steve, was seven at the time. The trusting relationship built with project staff over the course of an eighteen-month intervention enabled her to share her traumatic history with the team. Jeanette disclosed that violence and substance abuse characterized her childhood and early adulthood. Jeanette had numerous relatives who had been incarcerated for murder and violent assaults; she was the only one of three siblings who had not been incarcerated. Jeanette told the team that, although she had mutilated herself as a child, she never asked for or received any mental health services.

Although Jeanette reported that her son Steve was a good student, he was referred to protective services for excessive absences in the first grade. His mother was charged with educational neglect and he was retained in first grade. Steve went to school without difficulty but his consuming anxiety about his mother's safety and well-being made it difficult for him to engage in any activities away from her. The extent of his worries about his mother and sense of responsibility for her protection were demonstrated by his responses to her story. Jeanette, in Steve's presence, told the team of a time when as an active addict, she had sold her son's electronic games to support her habit. When Steve was asked for his reaction to the story, he was unable to validate it, worried that he would somehow endanger his mother. Finally, he suggested that his games might have been stolen or broken. He was only able to acknowledge the story after his mother gave him permission to tell the truth.

When provided an initial recommendation that Steve receive individual outpatient mental health services, Jeanette was unable to follow through. She believed that she had always taken good care of Steve and could not tolerate an exploration of the ways in which her active addiction and the chronic exposure to domestic vio-

Continued on page 39 . . .

Continued from page 38. . .

lence might have affected him. Recognizing that Steve would benefit from individual treatment, the clinician on the team offered to provide treatment in the home, a suggestion that was enthusiastically accepted by Jeanette. Steve used the sessions to explore and express some of the negative feelings with which he struggled. In treatment, Steve spoke of his anxiety during those nights when his mother did not come home and his perception that he was responsible for his mother not doing the “white stuff” in the bathroom anymore. Slowly Steve was able to participate in peer appropriate activities and to trust that while he was away from his home, his mother would be able to care for herself and his newborn sister. While Jeanette continues to struggle with her fear of being judged a bad parent during active addiction, she appears to have gained insight and understanding of the ways in which her behaviors affected her children.

not they are presently able to parent is safe, when it may be safe nowhere else. Some parents need to be given permission to speak the unspeakable -- that they are not able or willing to parent effectively at this point in their lives. Providing a forum for evaluating this extremely important question can empower parents to make difficult decisions on their own without coercion. Whatever the issue, the context of the relationship allows open, honest communication leading to the development of a plan of action with a resultant reinforcement of the family's abilities and the children's well-being.

Working with fathers and father figures

Recognition of the importance of fathers in children's lives led to their increased involvement in AIA interventions. AIA project staff reached out to fathers or the mothers' significant others with services (e.g.,

support groups; parental skill building) aimed at increasing their participation. Many fathers have proven to be exemplary parents and have assumed primary caregiving responsibilities for their children. Other fathers are ambivalent about their role in the family and AIA projects help them to resolve their uncertainty. However, the effort to involve fathers and father figures is complicated by the prevalence of domestic violence, partner drug use, and multiple fathers and partners. Many projects have assisted fathers to enter treatment in order to become parents that are more appropriate and maintain relationships with their children. Involving fathers in treatment is a complex issue that merits much more attention than it currently receives.

PROJECT VIGNETTE

The TIES Program in Kansas City, MO facilitates a women's support group for its participants and alumni. At present, the *Waiting to Exhale Women's Support Group* has been functioning for over four years. The group developed its own group rules, planned its own calendar, and agreed to plan one recreational activity and one process group each month. TIES Family Support Specialists act as co-facilitators for the process group. Its structure is loose and the facilitation as unobtrusive as possible while helping the women identify their issues and support one another. The project provides lunch, transportation, and limited child care for the group. The commencement ceremonies for families completing the project are held in conjunction with group. Over a long period, a core of presently enrolled and alumni women have been built, and the group encourages supportive personal relationships outside of its organized activities.

The TIES Program is also active in discussing family planning with each enrolled woman early in her involvement. Planning pregnancy is a natural part of the discussion about taking charge of one's life and setting goals. No one is discouraged from having additional children, but everyone is encouraged to think about timing and ability. Specific options and methods are discussed, and Family Support Specialists assist women in securing birth control services. If a woman indicates a desire for long-term protection or sterilization, she will be assisted in securing those. Within this context, women's health issues are addressed as well. Women are encouraged to attend postpartum visits and to follow up on any identified problems. There is discussion of sexually transmitted diseases, particularly HIV, and educational offerings are provided. Relationships are promoted with the area providers of women's health services to insure current information and prompt access.

Working with relative caregivers

Many families have significant involvement with extended family. These kinship systems are often providing support both to the parents and to their children. In other cases, women are dealing with the rejection of their extended families that are no longer willing to deal with the roller coaster of substance abuse. In many instances, they are providing most or

all of the care for children whose parents are involved with drugs. In still other families, substance abuse may be intergenerational and both parents and grandparents are substance abusers. It is important to identify and connect with this network as permitted by the enrolled family. Sometimes extended family relationships can be strengthened; sometimes they are severed. For each situation, the goal is to support

CLIENT VIGNETTE

Renee was referred to the CIWI Project in New Haven, CT following the birth of her third child. She used crack cocaine throughout her pregnancy and her two older children had already been removed from her care. After the initial evaluation, it became clear that Renee needed the intensive intervention of a drug treatment facility to achieve sobriety. With the support of the AIA team, Renee readily agreed to enter a short-term residential program with her infant.

During the course of her treatment, Renee made clear her plans to return to the home she shared with George, the baby's father, following her discharge. She inferred that George was selling drugs, but offered no opinion about the potential influence of his illegal activities on her attempt to remain drug free.

The AIA team continued to meet with Renee and her infant throughout the course of her residential treatment, working with her to clarify the role George played in supporting her addiction and to assess his ability to be a nurturing father for the baby. Shortly after Renee's return to the community, she and George moved to a new apartment in a supportive environment. The team found that George was able to provide appropriate care for his son and take pleasure in reporting the attainment of his son's developmental milestones. Although the team continued to have concerns about George's ability to support Renee's recovery, Renee was determined to remain with him.

Despite their unease, the members of the team worked to engage both Renee and George in the intervention, providing couples counseling, parent guidance, case management, and advocacy in their efforts to support the child's growth and development. Eventually, Renee decided to return to work full time and George became the primary caregiver for his son while she was out of the home. George proved to be a proficient father, who was sensitive to his son's needs. Renee was pleased by George's ability as a nurturer and recognized that he relieved her anxiety and made it possible for her to concentrate on her work. When the AIA team ended its intervention, Renee was engaged in an outpatient drug treatment and connected to a 12-step program, her son was thriving, and George, who enjoyed his responsibilities as a father, was no longer observed selling drugs.

the caregiving environment. Emotional support, education, emergency assistance, and access to legal services are needed for these caregivers. Extended families often need information about drug addiction and treatment and the influence of family interactions on these factors. Grandparents and other relatives need support and to know that they are not the only ones in this role. Recognizing the importance of supporting this kinship network, AIA funds have been directed to develop projects specifically for this population within AIA funding.

Voluntary relinquishment of children

While preservation of the biological family is a value shared by all AIA projects, some parents may not be willing or able to provide appropriate care of their children, even with the provision of considerable support and assistance. In these situations, the child's safety, stability, and permanence may only be achieved through voluntary relinquishment and adoption.

Voluntary relinquishment is a permanency option in which parents surrender their legal rights and responsibilities for the child to the state to allow that child to be adopted by someone else (Simmons, 1999). AIA projects recognize that parents need to be empowered to explore voluntary relinquishment as an option within the context of a structured approach and an accepting therapeutic alliance. The relationship enables the work to focus on the child's need for permanence while also respecting the deep challenges to each parent's sense of self that voluntary relinquishment presents.

In AIA projects, a discussion regarding voluntary relinquishment typically occurs after a relationship between the child's primary caregiver and the staff member has been established. It is often not until the

staff member receives the caregiver's direct verbal communication or nonverbal cues, suggesting that maintaining the child within the family is not an appropriate option, that the concept of voluntary relinquishment is broached. The most successful outcomes are elicited with honest and open communication rooted in the treatment alliance or helping relationship between the parent and staff member.

AIA projects that utilize the option of voluntary relinquishment have found it to be a complex task that is influenced by a personal and profound emotional loss on the part of the parent(s), as well as the regret and ambivalence of the many other adults involved in the child's life. The process of surrendering parental rights can be extraordinarily painful for both parents and providers. In fact, the steps leading to voluntary relinquishment are frequently slow and deliberate because of the many intra-familial, systemic, and legal issues and the need for parents to move through their own grieving processes.

AIA providers find that working with parents as they move towards voluntary relinquishment of a child is a fluid process. The client calls upon the staff to validate the expression of both positive and negative feelings. One day the client may appear to be fully committed to the plan of relinquishing the child to a new caregiver, the next day the client reveals deep ambivalence and self-doubt, and questions her ability to go forward with the plan. This may partly be the result of many well-intended providers and family members who make statements that discourage parents from voluntarily relinquishing their children. At this stage, many projects employ innovative strategies that include mediation and parent empowerment to facilitate the process. Each of these strategies defines a process that is inclusive of parents during the decision making process (Simmons, 1999).

CLIENT VIGNETTE

Quanetta was referred to CIWI shortly after the birth of her third child who was born with a positive toxicology screen for cocaine. At the time of referral, Quanetta had been observed roughly treating her two older children, ages four and eight, in public. Consequently, a hospital social worker expressed concerns about her parenting ability. The birth of her baby was followed by a protective service investigation that resulted in the infant's placement in foster care. Within weeks, it was clear that Quanetta's active addiction was also jeopardizing the safety of her older children.

With the assistance of the team, she was able to identify her sister, Janie, as a resource for the children. An attempt was made to reunite mother and newborn in a residential treatment program, but this plan was terminated when Quanetta left the infant in her sister's care during an extended pass. Ultimately, it was determined that all three children would be better served staying with their maternal aunt.

The aunt, a single parent of another child, became legal guardian of all three relatives. The AIA team provided supportive services to the aunt and remained involved with the children. The team advocated on Janie's behalf for funds to subsidize her guardianship of the children and helped her to secure a larger apartment and adequate educational programs for the older children. Once the children were settled, Janie used the team to explore some of the more complex problems of raising her niece and nephews. Although Janie encouraged contact between her sister and the children, Quanetta's ongoing substance abuse resulted in sporadic contacts that became disruptive to the family.

The intervention team helped Janie to understand that some of the children's behaviors represented reactions to past traumatic experiences. They needed time to work through the issues of separation and loss with which they were struggling. The team assisted Janie in structuring the children's contacts with their mother and providing connections with appropriate community resources for the children. In time, Janie and her extended family were able to develop the trust and affection that was essential to their stability.

Even providers whose careful assessments have led them to the conclusion that voluntary relinquishment is the best option for permanence for an individual child may find the work challenging and emotionally charged. This may be especially true of staff members who have had their own personal experiences with the child welfare and judicial systems as presented in the vignette below. However, some providers struggle with these issues even when their own history is free of addiction, physical illness, and other serious trauma. For example, staff members who are also parents may identify with their clients and find the potential loss of a child incredibly painful and sad.

Supportive supervision allows these feelings to be expressed and contained. It is during supervision that staff members can be helped to redefine their roles in the client's family and provide the support their clients need to make the best possible choice for their children. On-going training on the important topics of permanency, permanency planning, stages of loss and

grief, attachment and recovery can also assist providers to feel informed and empowered while doing this work

Despite the complexity of this work, many AIA projects have found that the benefits of voluntary relinquishment for children and parents outweigh the difficulties that are likely to arise. Successful use of this strategy to plan for a child's physical and emotional safety and stability depends upon the parent's capacity to act ultimately in the child's best interest and the staff member's ability to respect and accept the intensity of the issues that are inherent in giving up one's children. Well-trained and supervised staff able to cope with their own feelings, as well as those with which the parents must deal, can ease the pain and guilt for both child and the biological family. Together parents and staff members can help the child enter into a new family able to establish the reciprocal relationships that are essential for the child's on-going health and development.

PROJECT VIGNETTE

A *staff of peer counselors who are in recovery from substance abuse and/or HIV+ provides the majority of services to clients enrolled in Project SAFE, an AIA program in Florida that serves families affected with HIV and/or substance abuse. When asked about their experiences in discussing permanency with clients, the staff members were honest and shared how difficult it was for them to raise the subject with their clients. The mere mention of voluntary relinquishment dredged up their own past memories, feelings and emotions, and reminded them of their own mortality. They spoke of having felt threatened by the Child Protective Service system in the past, and having to work to overcome those feelings before being able to engage clients to discuss the topic. To address this, a grief and loss support group was offered to peer counselors, along with training to improve their skills in communicating and participating in the process of voluntary relinquishment.*

IN THE CLIENT'S VOICE

"My five children, ranging in age from three to nine, had been removed from my home because I was neglecting them: choosing to 'use' rather than take care of their needs. Someone reported me to the authorities and my kids were whisked away. I was angry, confused and could not understand (or was maybe just too high to understand) the impact it would have on my life. I fell into a depression that I thought could be fixed by another 'hit.' I was on the street, heavy into 'crack,' never worrying about anything except how high I could get. I never had a criminal record because I was able to exchange favors for my drugs. Yet, as I was fighting the system for custody of my five children, I discovered that I was pregnant again.

"My kids had been in the system for about a year and, although I always loved them, I could never clean up long enough to establish a good home for them. Unfortunately, because there were five of them, they were separated: three in one home and two in another. They were not only coping with being removed from me; they had to cope with being separated from each other. I tried to visit them but staying clean and sober was too hard at the time. I visited them when I was together enough to show up and I disappointed them many times when I chose the drugs over their visits. Fortunately, the agency staff that supervised the homes was understanding and allowed the children to visit each other. Their sibling bond remained intact but they were becoming increasingly detached from me.

"Rather than admitting myself into residential drug treatment and taking advantage of my children being safe and cared for, I remained on the streets. Discovering that I was pregnant again was still not enough for me to clean up my act. I continued to use and was clearly told that if I did not remain drug free, this baby would also be removed. I still thought I could handle it. Refusing drug treatment resulted in my sixth child never coming home with me. Instead, he was released from the hospital and placed directly into foster care. The social service workers tried to help me and drew up performance plans that I consistently failed to meet. I was still resistant and just two months later found myself pregnant for the seventh time. Again, I continued to use throughout the pregnancy. That baby was also removed from me in the hospital and placed in foster care. It took this seventh birth to convince me that my chances of reunifying with my children were running thin. I finally accepted the fact that I had a problem and entered a drug treatment center. I remained there for six months and began to slowly reestablish my life. I was committed to reunifying with my children and was compliant with a new performance agreement that was developed between my social worker and me. I found employment and housing, and began weekly visitations with my children."



Voluntary Permanency Planning for HIV Affected Families

LINDA S. COON
JANE ASCROFT

The AIA initiative has provided funding for demonstration projects that help HIV affected families make and carry out permanency plans for their children. These projects use interdisciplinary models of providing social work, legal, and other supportive services to help families develop their plans. In this way, permanency planning projects help divert children who might otherwise be at risk of foster care placement to safe and stable caregiving arrangements.

For the purposes of this chapter, voluntary permanency planning for HIV affected families is defined as the ongoing, elective process by which HIV infected parents/caregivers make decisions about the future care of their children in the event of their incapacitation or death. The majority of AIA funded permanency planning projects for families with HIV are voluntary and client-driven, meaning that the parent or caregiver makes the care and custody plan and the projects provide services to support and facilitate this process.

The majority of HIV infected women are of child-bearing age; they either have or will have children. Many of these mothers will become too sick to care for their children; some will die while their children

are still minors. Because of their situations, most parents living with HIV/AIDS have thought about what might happen to their children if they become unable to care for them. A lesser number, however, have taken steps to solidify a plan. It is quite obviously painful for parents to think about these issues, and to share their wishes with children, family, and friends. Talking about a plan often means disclosing the need for a plan and, therefore, disclosing one's HIV/AIDS status. It is difficult, as well, to know what to do once one has a plan in mind; many people do not know how to make a legal plan, and most lack legal and other supportive resources to do so (Boxer, Ascroft, Vazquez, & Coon, 1998). Service providers have long recognized that HIV affected parents need information, assistance, and support in order to plan for a time when they can no longer care for their children. This is the rationale behind several AIA projects around the country that help families make decisions about their children's future care and support new caregiving arrangements once a parent has died.

Characteristics of Voluntary Permanency Planning Projects for HIV Affected Families

Most AIA permanency planning projects provide an array of social support and legal services that are comprehensive, accessible to families, and responsive to their needs. Several represent unique, interdisciplinary collaborations among clinical and legal professionals, and other staff depending on the project model. Project staff may be housed together within one umbrella organization or in separate agencies. Successful projects are visible in their communities and have good working relationships with other HIV/AIDS service providers, complementing rather than duplicating services available to HIV affected families.

Most AIA permanency planning projects agree that experienced and committed social workers and legal staff, working together to help families make plans, are essential. Attorneys experienced in permanency planning are quick to note that the process can be much more difficult when parents/caregivers have not been prepared for the legal stage of planning by clinical support staff. Likewise, social workers can only take a family so far in the planning process before they need assistance from legal staff to help make and implement the legal plan that is most appropriate for the family's situation. Permanency planning devices can include standby guardianships, wills, powers of attorney, living wills/advanced directives, guardianships, joint custody agreements, adoptions, or standby adoptions.

Clinical social work

Effective permanency planning projects use social workers to provide a broad range of social services. These can include:

- Social work services that support development of legal plans, which may include problem-solving and identification of a potential caregiver; family conflict resolution; family meetings, including meetings around disclosure of HIV/AIDS status; and linkage to legal services and to other social services.

- Supportive therapeutic interventions are also offered to help stabilize families as they work toward developing a permanency plan. Therapeutic interventions designed to support healthy family functioning may be offered by permanency planning projects because many HIV affected families have a history of involvement with the child welfare system. For example, nearly half (48%) of the families served by Chicago's Family Options Permanency Planning Project have been involved with the state's child welfare agency. Many of these families have regained custody of their children, and are working toward making future plans. Parenting skills development has thus become an important component of the Family Options Project, and because many of the project's clients are either young mothers, mothers who have only recently begun parenting their children, people who lack sufficient parenting skills, or older caregivers who have out of necessity started caring for young children. Therapeutic interventions also include individual and family counseling, grief counseling, HIV education (especially the impact of HIV/AIDS on families) and peer support. In addition, referrals for additional HIV/AIDS services, mental health and substance abuse services, and advocacy for public benefits are provided.

- Social work services are also provided to new caregivers to support the transition of the children into the home and create a stable family environment for the children and the new family. These services can include grief counseling, conflict resolution, parenting skills development, education on the impact of HIV on families, and referral/advocacy to public benefits and mental health services.
- Many permanency planning projects also provide opportunities for peer support, such as retreats, social activities, support groups, and special events.

Securing a legal plan

Legal services are provided by permanency planning projects to help parents and caregivers customize plans that meet their needs. These services include securing court ordered permanency plans for children, and other services to stabilize a family and support its legal plan, including assistance with public benefits and other advocacy.

Permanency plans are designed to meet the needs of individual families and children. For example, parents who are very ill or near death may want to transfer guardianship to a friend or relative immediately.¹ Other parents who are relatively healthy may be interested in standby guardianship, which allows them to keep their children in their care as long as possible and at the same time ensure that their permanency plans for the future will be legally valid.² This legal option, now available in at least 20 states, provides parents the opportunity to testify in court as to the best interests of their children while they are still able to care for their children.³ It also provides peace of mind to parents who know that their chosen legal plan will take effect when needed.

Another option available in some states is short-term guardianship or a similar temporary caregiver designation device. This type of private agreement between a parent and another adult does not require court approval. It is often used during the course of developing a permanency plan when a family wishes to delegate decision-making authority to another person on a temporary basis. For Example, short-term guardianship might be useful in situations where a parent is hospitalized or experiencing a serious illness but is expected to recover.

Many of the aforementioned legal options have been developed over the years in response to the AIDS epidemic and the growing numbers of children

1 Inter vivo guardianship is a complete and immediate transfer of guardianship from a parent to another qualified adult during the parent's lifetime. A petition must be filed (usually, but not always, by the parent), and notice must be given to persons entitled such as the children's other parent. A best interests hearing is then held by the court, and if the court approves, the care and custody of the children, and many other decision-making rights (including health care and educational decisions), are assumed by the guardian.

2 Standby guardianship is a mechanism for ensuring legal permanency for a child that is contingent on the occurrence of a future event—usually the death or incapacity of the parent. In essence, the standby guardian literally “stands by” until needed, and assumes responsibility for the child once the standby duties are activated. As of September 2002, standby guardianship laws have been enacted in 22 states. Each state has its own statutory and procedural requirements for standby guardianship.

3 Two states (California and Connecticut) allow parents to establish joint or co-guardianships, in which a parent may nominate another person(s) to serve in a shared guardianship capacity with the parent. This type of guardianship could enable the parent(s) to retain custody while ensuring that the joint or co-guardian will assume full guardianship responsibility, including care and custody, when needed.

orphaned as a result of AIDS.⁴ They have been designed to increase permanency outcomes for HIV affected children, in some cases preventing children who lose their parents to AIDS from entering the child welfare system. Before the enactment of standby, short-term, and/or joint or co-guardianship laws, parents relied on conventional legal planning mechanisms, like wills. However, the initiation of future guardianship through a will (called a testamentary guardianship) does not ensure, in and of itself, that a court will appoint the person nominated by the parent as guardian of the child.⁵

In contrast, standby guardianship provides a way in which the parent's testimony can be taken (while the parent is living), and helps ensure that children can live with the parent for as long as possible while still providing a future legal permanency plan. Before standby guardianship, parents had to give up custody and control of their children if a guardian was appointed for the child while the parent was still living. With standby guardianship, the family can also have some peace of mind, knowing that the parent's plan for the child can be implemented when needed.

⁴ In 1994, an estimated 7,300 children and adolescents in the United States were orphaned by HIV/AIDS. By this year, 2000, it is conservatively estimated that the overall number of motherless children and youth will exceed 80,000 and may rise to 125,000 (Levine & Stein, 1994).

⁵ Though courts generally give preference to a parent's wishes, guardianship nomination through a will is not legally dispositive; that is, the court is not bound by the parent's preference. Another person with legal standing can contest testamentary guardianship nominations, and the court can find that the parent's choice of guardian is no longer in the child's best interest. As is the case with any guardianship, if the child has another legal parent, the court may not appoint another person to be the child's guardian unless the legal rights of the other parent have been terminated, or the other parent agrees to the guardianship.

Several AIA funded permanency planning projects have worked to help establish standby guardianship and other permanency planning reforms in their jurisdictions.

The importance of achieving legal permanency for HIV affected children cannot be overstated. A good plan is critical to the child's ongoing safety and well-being. Without a legal permanency plan, a child who loses a parent to AIDS may be without a legal guardian, or may be at risk of abandonment or foster care. Even in cases where family members step forward to care for the orphaned child, the absence of a plan can lead to conflict, chaos, and additional trauma involving a child already dealing with the death of a parent. Supportive legal and social work services can help prevent disruption of families before legal plans are made, as they are implemented, and after the child's transition to the new caregiver.

Lessons Learned

Permanency planning projects across the country serve an important role by diverting cases of children who might otherwise be at risk of child welfare involvement by helping their families make and carry out their own voluntary permanency plans. Since the initiation of these projects in the early 1990's, a number of lessons have been learned that may be useful to providers who would like to develop permanency planning projects in their communities.

The process of completing a permanency plan can be lengthy.

Permanency planning is more time intensive than many service providers originally anticipated. Even with the support and services provided by permanency planning projects, parents with HIV/AIDS face

extraordinary burdens and challenges as they plan for the future care of their children. Legal and psychosocial issues that HIV affected families face when making a plan can include:

- reluctance on the part of the parent to disclose his or her illness, which may pose a threat to family and other relationships, employment, religious and community status, and personal safety;
- the prospect of facing a legal dispute with the children's other parent(s) or another person with legal standing, who may oppose the custodial parent's wishes;
- the presence of substance abuse and mental health problems;
- a family's current or past child welfare system involvement, which may impede planning for families who lack the authority to make their own plans (because the child welfare system has custody of the children);
- a mistrust of the legal system, which family members may perceive as having treated them unfairly in the past;
- the challenge of securing a legal plan that is responsive to the child and family's needs for permanency and supportive benefits;
- acceptance or denial of the infected family member's HIV/AIDS status; and
- the challenge of identifying a willing and able substitute caregiver.

Given all of these barriers, it should be no surprise that it can take months and even years for some families to make plans. For example, families participating in the Family Options Project take an average of eight months to complete a legal plan for their children.⁶ Some families begin the planning process, have that process interrupted by other, more pressing issues within the family, and then re-engage in planning when they are able to focus once again.

Not everyone will make a legal plan, but parents can make important progress toward planning.

Parents may not complete plans for a variety of reasons, e.g. the onset of sudden illness, a mistrust of the legal system, or the emotional difficulty of facing death. Kin caregivers may not want to formalize a plan that will change family relationships and intrude on parents' rights. With the assistance of a permanency planning project, however, parents may decide on someone that they would like to care for their children, such as an aunt, and talk with the potential caregiver about doing so. In these cases, the progress made towards planning, although not legal, should be considered significant.

HIV affected families who engage in planning often require a range of therapeutic and legal services.

HIV affected families who engage in planning often require a range of therapeutic and legal services that address their multiple issues and support family stability, safety, and permanency. It is only when these needs are addressed that families are able to focus on making care plans for their children.

- Social work services are needed not only to engage families in legal planning, but also to support healthy family functioning by addressing families' multiple needs. As stated previously, permanency planning can be a lengthy process and demand a range of services and skills from social work practi-

⁶ For purposes of this article, a completed legal plan includes either a court ordered permanency plan (such as a standby guardianship), or another legal plan secured by legal documents to support the parents' plan for future care and custody of the child (such as a short-term guardianship or similar temporary caregiver designation device, and/or a will).

tioners. In many cases, social workers associated with permanency planning projects address a variety of clinical issues in order to facilitate planning and to promote healthy family functioning. Some of the issues that permanency planning project staff must address include: parents' and children's fears about health and death; parents' difficulties around disclosing HIV status to family; questions about HIV and AIDS as well as antiretroviral regimens; tension and conflicts that often arise when family members and birth fathers become involved; and parents' spiritual beliefs that planning betrays faith in God's plan for themselves and their families. Some of the barriers addressed by project clinical staff include parents who, for a variety of reasons, cannot identify an appropriate future caregiver; children's behavior problems, as identified by parents and caregivers; issues about parenting and a lack of parenting skills; closure that some parents feel is negative closure; and the financial strain that characterizes many of the families.

- The provision of supportive legal services to stabilize a family's situation can help engage families in permanency planning. Frequently, parents or caregivers approach permanency planning projects with requests for assistance on matters that are not of a direct permanency planning nature, such as legal assistance to address problems with access to cash, medical, disability, or housing benefits, or legal assistance to address discrimination and employment issues. By offering legal services to assist with more immediate needs and forming relationships with the families, projects can sometimes engage more families in the long-term task of permanency planning.

Assistance with public benefits can be critical to a permanency plan.

Some permanency planning projects focus significant amounts of time and energy on public benefits, which are critical to low income, HIV affected families. First, families are assessed for public benefits eligibility with the goal of improving their overall financial stability and ensuring their access to health care. In addition, it is important that project staff help families determine whether their preferred future caregiver will have access the resources necessary to provide care for the children. Ensuring that caregivers, both current and future, optimize available benefits for the family helps to secure a permanency plan and prevent high risk families from becoming involved with the child welfare system.

Additional legal services are often provided to support the family's permanency plan.

Such services might include assistance with powers of attorney for health care and property as well as wills, in addition to the assistance with benefits described above. Powers of attorney can help parents designate agents with the authority to make health care or financial decisions when they are unable to do so. These designations will have an impact on the children's well-being during periods of time when parents are not able to act for themselves. Living wills and other advance directives are also used in some states to indicate a person's wishes regarding treatment in specific circumstances.

By executing a will, parents can provide for the disposition of property that will take effect after death, potentially ensuring that available resources go to their children. Wills may also be used to express parents' intentions concerning guardians for their children although, as stated previously, a court may

decide that such plans are not in the best interests of the children.

Some families need more than one permanency plan.

Many families develop more than one plan to ensure permanency for their children. For example, a mother may want to have her current husband adopt her children so that the children will remain with him if she dies. This family may also be encouraged to develop a standby guardianship arrangement so that a future caregiver of both parents' choosing will step in to care for the children if something happens to them. Alternatively, children in a family may have

more than one father, which may affect the choice of future caregiver and the type of legal plan selected for each child.

Some permanency plans will need to be reworked.

Plans often have to be reworked, most often because a prospective new caregiver becomes ill or otherwise unable to assume care for the children. Permanency planning project staff work diligently to ensure that parents have made solid decisions that are appropriate and feasible before the plan is legalized to prevent having to rework a plan at a later date because the parent changed his or her mind.

CLIENT VIGNETTE

Mr. And Mrs. King had met and married several years ago after meeting in a substance abuse treatment center. The Kings contacted Family Options, an AIA project in Chicago, IL about making a permanency plan. An attorney first helped Mr. King adopt Mrs. King's three daughters from a previous relationship. Additional services enabled Mr. King to acknowledge paternity of the king's daughter, who was born prior to their marriage. The kings then decided to obtain a court appointment for Mr. King's brother to be the standby guardian for all four children.

Less than a year after completing these plans, Mrs. King became critically ill and died. Six months later, Mr. King died suddenly. The children's uncle was at that point unable and unwilling to assume his standby guardianship duties. After some prodding, he agreed to support the family's plan to have the oldest king daughter, then 26, become guardian of her younger sisters.

CLIENT VIGNETTE

Gloria Adams, a young client working with the Family Options Project. Over a period of many months, Gloria changed her mind several times before settling on separate care plans for her three children. Marital problems, the progression of her illness, and the family's risk of child welfare involvement were among the factors influencing her decision-making. An attorney assisted Gloria in the completion of three short-term guardianships, two powers of attorney for health care, two powers of attorney for property, two wills, two standby guardianships, one private guardianship, two children's Social Security claims, and a public aid case.

Aftercare services are critical components of permanency planning projects.

Aftercare refers to the stage in planning after a plan has been implemented, due to the death or incapacity of a parent, when the children have moved in with the new caregiving family. Several projects continue to provide social work and legal services at this time to the new family to support their needs and preserve the placement. Issues that commonly arise for newly reconfigured families include grief and bereavement on the part of the children and the caregiver; the financial strain experienced by the caregiver to support the additional children; parenting concerns and the children's adjustment to their new home; and the family's adjustment to their new roles and family members. To address these issues, social workers may assist families with problem-solving, parenting skills development, and family counseling.

Legal services are often provided in aftercare as well. Depending on the state law, project attorneys may need to help standby guardians obtain guardianship

of the children after the parent has died or become incapacitated. Attorneys may also help new caregivers access benefits on behalf of the children now in their care. Lastly, attorneys may provide services to families interested in successor planning or reworking a permanency plan.

Provider and client education are also critical to the success of permanency planning projects.

Health care and case management providers need a basic understanding of the legal options available for children's permanency, and of the legal services available in the community. This type of education can help them become more comfortable in addressing permanency planning issues with their clients. Education and outreach to clients are also important to the success of permanency planning projects. As clients become more aware of the options and more knowledgeable about the legal process, their mistrust of the legal system may decrease and they may feel more empowered to seek legal assistance in securing permanency plans for children.

The older population of new caregivers can benefit from making permanency plans.

Frequently, it is the grandparents, aunts, and uncles of children who are orphaned by HIV who become their caregivers. This population of relatively older caregivers can benefit from planning for children in their care so that, if needed, a successor caregiver can step in and assume responsibility. “Successor permanency planning” might also be beneficial for any caregiver, regardless of age or health. Permanency planning staff should routinely work with families to explore the need for successor caregiving plans.

Involving different family members in a permanency plan can help the family reach agreement.

Some AIA permanency planning projects use a family meeting model to help families reach agreement concerning the permanency plan. Family meetings, generally facilitated by clinical staff, are often used to resolve conflicts within families around proposed plans. Earlier in the planning process, these sessions may help parents consider various placement options, or provide opportunities for them to express special wishes for their children or child rearing preferences.

Available permanency planning options for families need expansion and refinement.

This is especially true in states without standby guardianship legislation, where planning options are severely limited. Even in states that have standby guardianship laws, permanency planning staff often finds that the options available to them do not always provide the flexibility and security needed in some situations. Thus, for example, Illinois recently enacted a standby adoption law to help provide the greatest degree of permanency possible children who

may be orphaned. The new law was developed to respond directly to the needs of Family Options clients who wanted more permanency for their children.

Standby adoption provides for a court appointment of a person specifically selected by a parent who is terminally ill, who will act as standby adoptive parent until the parent dies or the parent requests that the court finalize the adoption, at which time the court will finalize the adoption unless it can be shown that it is no longer in the child’s best interests to do so. In addition to providing a higher degree of potential permanence than standby guardianship, standby adoption should also provide peace of mind to parents who want the security of an adoptive appointment, but who also wish to maintain custody of a child for as long as possible.

Standby adoption is an example of an innovative legal mechanism developed in response to the needs of families affected by HIV, including families served by Chicago’s Family Options Project. AIA permanency planning projects can play an important role in identifying and providing education about the legal needs of HIV affected families.



Effective Practices in Staff Development

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Model programs and effective strategies require experienced, well-trained, and well-supported staff. This chapter is devoted to a discussion of staff development and related human resource issues.

The therapeutic alliance between an AIA staff person and a client develops over time, and is based upon trust and a nonjudgmental approach to the difficulties experienced within the family system. Supportive supervision enables staff members to maintain their connections with clients so that the relationships remain productive, therapeutic, and focused on the needs of the families.

During the critical engagement phase, staff members demonstrate an ability to empathize with women, who are considered, in many arenas, to be “involuntary,” “resistant,” and “difficult.” These are labels placed on women who, due to their experiences, have become mistrustful of those presenting as helpers and who are struggling to contain their own feelings of shame and guilt. It is common for women faced with the consequences of their addictions to employ defenses, such as denial and avoidance. The need for persistence and dogged determination can-

not be overstated. This translates to being consistent, keeping appointments, and reaching out to families countless times even in the face of limited response. Workers frequently call on families and the door is not answered, although it is evident that someone is home. Calls are not returned. Appointments are not kept. Confidences are not shared. This must not deter the worker from keeping the commitments he or she has made. As time passes and workers persevere, families come to view this intervention as different from those in the past, and may collaborate with the AIA program in a way that has not happened before. This does not occur until distrust has been worn down a bit and the worker has

IN THE CLIENT'S VOICE

“(My worker) is very caring; she is very supportive emotionally. She listens without a lot of judgment against you.”

demonstrated his or her interest and reliability, no matter the circumstances. Some projects require families to initiate specific (and sometimes difficult!) steps in order to be discharged from the project. In the face of such persistence, families may decide to attempt the project rather than continue avoidance behaviors.

Approximately two-thirds of women treated for addiction have a co-existing mental health disorder. Frequently, an active addiction masks the symptoms of the psychiatric disorder. Past traumas also play a significant role in the lives of addicted women, with a majority reporting a history of physical and sexual abuse. Thus, interventionists must work to overcome the barriers that may inhibit women from establishing a trusting relationship. This is done by employing strategies that allow the worker to connect with the client in a manner that is personal and accepting, and respectful of professional boundaries.

Enabling staff to do the difficult work of intervening with substance and HIV affected families requires not only consistent, competent individual supervision, but also a commitment of project administrators to support staff and provide the time and resources for ongoing training. Two common themes have emerged from the experiences of AIA projects. The first is the need to create ongoing opportunities for staff members to process their work. These opportunities, both formal and informal, allow staff to express their personal feelings about the work and to learn from both their experiences and those of their peers. Secondly, is the need to recognize the power and significance of the parallel process. Defined previously, the parallel process indicates that staff, in their everyday interactions with clients and other community providers, will replicate the experiences of their supervision.

Team Intervention

AIA projects employ a wide range of professionals and disciplines including medicine, psychology, social work, nursing, and law. Each project has organized its team and recruited staff based on their own theoretical model, the needs of their community, and the resources available.

Whereas some AIA projects rely solely on master level clinicians for direct service to clients, others rely solely on paraprofessionals. Paraprofessionals, often women in recovery, typically have no formal degrees in the helping professions but have either life or work experiences that enable them to work well as a natural helper with troubled families. Various identified as “home visitors,” “family advocates,” “family service workers,” “peer workers,” “case workers,” or “paraprofessionals,” the workers usually reflect the same community culture and experience as the families they serve. The work of paraprofessionals has been described as the “blurring of the worker-client boundaries” (National Abandoned Infants Assistance Resource Center, 2000). This “blurring” has both positive and negative implications.

The role of the peer worker varies across AIA projects. In most cases, these workers assist families in obtaining basic services, either accompanying them on medical, social service or project activities, or they “generally act as brokers or liaisons between clients and institutions, and between professional and lay attitudes and behaviors” (Price, 1994). They may be expected to model parenting skills or to act as advocates on behalf of the families, helping them to interface with community providers and systems that are often unresponsive to their needs. This group of workers is well suited to the task of breaking the bar-

rier of client resistance. In treatment projects, their roles are fluid, acting as confidant, role model, or coach. Probably their greatest potential asset is their ability to enhance client engagement, since families are generally receptive to workers who are more like themselves.

IN THE CLIENT'S VOICE

"I wouldn't be where I was today if I didn't see that someone else got through what I was going through."

"If she's been through it, then she knows what she's talking about."

The use of paraprofessionals creates a need for focused and ongoing training and heightened supervision and support. AIA projects using peer workers have come to recognize their contributions, but also understand the challenges they pose. Some projects have reported that peer workers are at risk for aligning themselves with the client in a way that jeopardizes the therapeutic relationship. Often facing the same issues of recovery as their clients, the peer worker is also vulnerable to relapse. AIA projects have also learned that they must address and nurture the relationship between unlicensed and licensed staff. If it is not, territorial "ownership" of families becomes a struggle and interferes with appropriate clinical work.

AIA projects have addressed these staff management issues with specific strategies. The majority of AIA projects offer strong, supportive supervision, policies that delineate roles and responsibilities, and training to promote competent, knowledgeable, and caring staff. With open and trusting supervision, their past experiences, both positive and negative, can be used to benefit client recovery and assist staff members to understand the family dynamics from another perspective. An innovation tried by several AIA projects is the pairing of unlicensed and licensed staff as a case management team.

Staff Characteristics and Recruitment

Whatever the staffing choice, there are specific personal and professional competencies that should be considered in recruiting and interviewing staff:

An ability to engage others

AIA projects accept the engagement process as a critical component of their interventions. Individuals entering the field need to demonstrate skills in establishing a safe environment for clients to share and a willingness to contain their own expectations of what *should* be happening during this initial phase of the intervention.

An ability to tolerate the work

Poverty, trauma, abandonment, substance abuse, chronic illness, HIV infection, and violence have been common themes in the lives of families served by AIA projects. Hearing their stories, participating in permanency planning for children, and ultimately accepting parental choices, that may or may not reflect the recommendations of providers, can provoke feelings and emotions that are difficult to accept. Providers need to demonstrate a capacity to

PROJECT VIGNETTE

Project SAFE, in Miami, FL, plans, delivers, and evaluates a family-focused, peer-based, early intervention home-based case management program for women and their children. The staffing pattern used to achieve successful outcomes is a peer-based model. After evaluating the outcomes achieved in the very early stages of the project, it was determined that using professional staff to provide home-based case management services to the women and their families was not producing the positive effects anticipated. Clients mistrusted the staff members, who were unable to engage them. Staff feared entering some of the more dangerous drug ridden neighborhoods and avoided regularly visiting clients' homes. The staffing issues were revisited and it was determined that peers had the potential of producing better outcomes. Administrators set out to hire peer staff, indigenous to the client population. The peers were not only intimately familiar with the problems of substance abuse and HIV; they lived in the very community that was targeted for the project. The staff had a sense of the "street" and each brought life experiences, rather than employment experiences, to the positions. They were able to relate to, and communicate with, clients on a level that the professional staff was unable to do. In essence, they "walked the walk and talked the talk." The peers also had first hand involvement with the state social services, having had their children removed from their custody because of abuse and neglect related to their drug use and reunified after successful completion of a case plan. They did not present themselves as anything more than whom they believed they were — HIV positive, recovering addicts, mothers who had hit rock bottom and fought their way back to becoming productive adults. They were proud of their accomplishments and had no fears of sharing their experiences in order to help others.

cope effectively with the emotional pain families experience, and that which they experience personally.

An ability to make decisions in the field

This is particularly true for those providing home-based interventions. Both clinicians and paraprofessionals will encounter situations that are unexpected and unprecedented. These moments demand a calm, rational, thoughtful approach. While discussion and validation can be sought after the incident, the immediate situation requires sound clinical knowl-

edge, as well as the ability to provide safety plans for both the worker and the family.

Internalized belief in the core philosophy of the strength-based, nonjudgmental approach of the project

During an employment interview, it is essential to solicit a candidate's thoughts and feelings regarding women who use substances during pregnancy. While many professionals believe that they approach all of their clients in a nonjudgmental fashion, direct

questions regarding parenting and illicit drug use can often bring to light a discrepancy.

Comfort with home visiting as an intervention

Providing a home-based intervention stretches boundaries and a clinician's sense of control. Delivering services in the home provides a wealth of teachable moments. Flexibility is necessary to take advantage of these moments. A rigid or uncomfortable approach may result in lost opportunities.

An ability to tolerate confrontation and rejection

Relationships are fluid and based on positive and

negative experiences. AIA projects have found that the development of a trusting relationship encourages clients to offer the provider large amounts of information. It also fosters frequent confrontation that may feel uncomfortable initially, but is necessary to move the work forward. One AIA client described this situation while reflecting on what it was like when her clinician informed her she would be sharing the news of her relapse with her child welfare worker, "I knew it was going to go further.... I had to tell somebody, so I kinda threw it on her, cause that's what they're there for." When asked how she felt when confronted she stated, "Relieved in a way."

CLIENT VIGNETTE

L*ouise became known to AIA staff following a referral to the project specifically for assistance with permanency planning for her four children, ranging in age from 4 to 11. Louise was at death's door, wasting away, 5'7" and weighing 65 pounds and barely able to muster up the strength to walk and talk. Her body was very frail and her face had the appearance of a skeleton with a small amount of skin around the bones. She knew her time was very near and although she was about to enter a nursing home, she was determined to make a permanency plan for her children. She was fortunate to have two sisters who were willing to accept responsibility of her children; therefore, she was confident that she could plan for her children by voluntarily signing surrenders to terminate her parental rights and relinquish custody to one of her sisters. Louise was one of the first clients referred to Project SAFE and certainly most in need of immediate services regarding her children's future. We contacted Legal Services and successfully established collaboration with them for Louise.*

The peer counselor assigned to this case was struck by her own mortality triggering a roller coaster of emotions for her. The project director had to take additional steps to ensure that the staff was equipped with the necessary tools to remain emotionally healthy, while facing the reality of their lives running parallel with the clients because of their own history. In addition to supporting the staff in a variety of ways, a therapist trained in issues of grief and loss was hired as a consultant for the peer staff.

IN THE CLIENT'S VOICE

"She is a very outgoing person. You know, she fits right into anywhere. So it had a lot to do with her attitude towards what she thought about me and the babies. They came out and every day that they did see the babies, it was like 'Wow! They're just so gorgeous, and they're just getting bigger and bigger. And they look so healthy and happy!' It was a lot to do with her non-judgmental attitude. She is really a great person. Just the way she handles things. She is at ease herself which means when you are at ease and you go and deal with someone, you pretty much put them at ease."

IN THE CLIENT'S VOICE

"They referred me to a caseworker and I was a little scared, because I was afraid they were gonna take my daughter away, but they were just helping me work through the drug problems I had and being a single parent. And I hit it off with my caseworker real good."

The provider struggled out of fear of damaging the relationship and destroying what trust was established. In retrospect, it was clear that *not* acting on the information would have been more damaging to the relationship.

Cultural Competence

AIA projects have recognized the importance of providing culturally appropriate services to a diverse group of clients. Core to their programmatic foundation, AIA projects have provided services by multicultural providers, provided bilingual informational materials to their clients, used therapeutic approaches and curricula that are respectful and culturally accepted in their service areas, and sought staff training in this area. Staff, when possible, reflect the community being served. Furthermore, services that are family-centered and designed in collaboration with the client are more likely to be culturally appropriate. What remains clear is the need to consider cultural diversity at all phases of program and staff development.

The employment interview needs to be an opportunity to solicit information, as well as share the nature of the work and discuss the clients' realities. Sharing client's stories from beginning to end — cases in which clients achieved goals and cases that are deemed unsuccessful — can be instructive. Sharing these case scenarios provides a realistic framework for dialogue regarding interventions and expectations of the program. In at least two of the AIA projects, the interviewing process includes a group introduction to the project staff that provides all staff members the opportunity to ask the candidate questions and dialogue about the work. The feedback can provide tremendous insight into the candidate's "goodness of fit" with the project.

AIA projects have adopted several recruitment strategies that have proven to be quite effective. These include using current staff members, who can provide a realistic description of the work, as recruiters. In addition, many of the projects have hired interns who have had an opportunity to work in the field with intensive supervision.

Fostering a Positive Staff Climate

A positive climate supports staff to feel safe to share and express themselves, feel a connection and shared commitment to the goals of the project, and participate actively in the process of program development. To accomplish this, programs must provide opportunities to discuss the project design and the knowledge that has been gained through the work. Often AIA projects are set within larger institutions such as hospitals and universities. These projects have found that a respectful approach towards staff, that values their knowledge and insights, fosters trusting relationships with supervisors, peers and clients. The unique nature of the AIA interventions may set staff apart from their colleagues. Administration and management can address this by actively soliciting staff to participate in events of the larger institution, encouraging staff to share their work through case presentations and in-service training, and providing opportunities to look critically at the project and its effectiveness.

Another essential component of a positive work environment is a strong peer support network. Staff members maintain a programmatic focus on safety, stability, and permanence for children, while working with others in the community who may have different priorities. Building the necessary collaborations requires skill, commitment, and a reliable support

network. An atmosphere can be created in which all staff members feel comfortable and safe sharing their successes, as well as their disappointments and challenges. A team that supports its members is receptive to the ideas of others, and open to community collaborations.

Support occurs through both informal and formal channels. AIA supervisors can allow regular opportunities for staff to communicate openly about the work and about their personal response to it. Successful team building activities within AIA programs include:

- consistent staff meetings where an open expression of ideas and feelings is encouraged;
- case presentations that allow the interactions of a diverse staff to provide new perspectives;
- staff retreats that allow and encourage staff to build relationships with each other based on mutual trust and respect;
- focused discussion groups on the lessons learned from both successful and challenging cases; and
- community presentations made by the group regarding their work and learning experiences.

Building a Supportive Supervisory Climate

Effective supervision is an essential element for all AIA interventions. AIA programs have found that quality supervision enables staff members to reflect on their work, learn from their experiences, remain faithful to the treatment goals, and find the support they need to continue performing the work with positive regard for the families they serve. The process of supervision mirrors the process that takes place between the staff member and the client.

However, in supervision and in the work with clients, there are occasions when confrontation and frank discussions are needed in the interests of the children and family. Staff must be held accountable for their behavior and helped to grow professionally and personally. In this way, supervision provides opportunities to model the skills essential for working with families affected by substance abuse and HIV.

Individual supervision provides a safe environment to explore both the process and content of the work. Maintaining a long-term relationship with clients, who are struggling with a multitude of problems, can be as frustrating and anger provoking as it is satisfying and fulfilling. There will be times when a client's behavior is disappointing and difficult to accept. A safe place is needed to let off steam, express anger, and regroup when the work threatens to become overwhelming. Supervision is the place to develop, not only an understanding of the behavior, but also a method of coping and the skill to reflect to the client, in a productive manner, an interpretation of the behavior. During the period of engagement and other critical times during the intervention, clients who are ambivalent about making changes in their lives may provoke feelings of rejection. What does it mean to a staff member when they continue to return for appointment after appointment although the client has been unable or unwilling to open the door? How are helpers affected when they are repeatedly kept at a distance by half-truths, broken engagements, and denials? Supervisors can assist staff to identify and understand their own reactions, values, and beliefs when they are challenged and to recognize the meaning of their presence in the client's home.

Supervising staff that provide home-based interventions requires careful attention to boundary issues and to the experience of providing services in a non-traditional setting. Supervisory sessions should include concrete and clinical discussions of how providing a service in the home affects the therapeutic relationship. In some environments, a simple offer of food or drink may provoke a host of feelings for both parties. These moments may occur unexpectedly and yet set a tone for future interactions. Ideally, decisions about mutuality and reciprocity should be clinically based, with the specific needs of the client and treatment plan in mind. However, staff members also have personal reactions and expectations. As one clinician stated about a client grandmother, "She always has to feed me." Ultimately, they had to negotiate around the issue of food to meet both the client's needs and the clinician's concerns. Working in the client's home, when the helper is a guest, raises many issues that are not generally encountered in a more traditional social service setting. Supervision requires an open dialogue to explore these counter transference experiences in the context of the therapeutic alliance.

Role definition and the limitations of the work can be equally challenging. While most service providers recognize engagement as a pivotal period of the intervention, termination can be just as challenging. In supervision, helpers can recognize a client's need for closure although some goals have not been attained. Supervisors assist staff to let go and accept the consequences of self-determination in keeping with their expectation that clients take control of their lives and set their own goals. Witnessing the transformation of women during recovery is a powerful experience. Recognizing the strengths of individuals often leads to high aspirations for families.

However, clients themselves may choose other roads and feel satisfied with smaller gains. It is through supervision that staff can explore their role with the family and assess both the verbal and nonverbal cues clients provide about their choices.

Supervision of staff aimed at addressing these intimate issues most often includes the following elements:

Consistency

Regular conferences provide a framework that model the structure needed to deliver the intervention. The supervisor must commit time and energy to the conferences and demonstrate the priority she/he places on this important consultation.

Relationship building

The supervisor needs to communicate respect for the staff's abilities and a willingness to learn as well as instruct. The supervisory consultation must be an exchange that explores options and develops plans that parallels the work with families. Without an open, supportive relationship between staff and supervisory staff, exploring these topics will be impossible.

A low supervisor-to-staff ratio

Providing adequate time for supervisors to encourage in-depth case review and provision of adequate support is essential. Supervisors need time to build these effective relationships.

Flexibility

It is important to encourage staff to be open to change and to be able to adapt and revise treatment goals when needed. The program design, as well, needs to be flexible and able to respond to changing

community and service needs that are identified by staff and families.

Accessibility

In many AIA programs, families have access to some staff members on a 24-hour basis to deal with crises. The provision of crisis intervention also requires access to supervisory consultation at all times.

Training

Staff development and training are essential elements of all AIA programs. Over the past ten years, AIA programs have evolved as the needs of clients have changed. These changes have included new medical advances, updated child welfare policies, social welfare policies, and shifts in the societal views of how to serve families in need. All of these changes and the steady stream of new challenges brought by clients present important opportunities for training. In addition, the venues in which clients are served, ranging from homes to residential treatment facilities, present unique training opportunities.

Training is most effective when the following are demonstrated:

Responsiveness to staff needs

Staff members will identify the areas in which they want further training through direct suggestions and feedback. Supervisors should note the themes that emerge during supervision and group meetings. Staff should then be engaged in structuring the training for themselves. This may include identifying a trainer, conference or modality. Ideally, it will also include a willingness of individual staff members to share their skills developed both through training and experience.

*Awareness of the uniqueness of the community
culture and geographic location*

Staff members and clients are in the best position to provide expertise and feedback regarding community values, needs, services gaps and effective intervention. Staff members should be invited to share their own culture and be encouraged to act as trainers/consultants for the group.

Providing staff with the skills and support they need to accomplish the difficult task of intervening with multiply challenged families demands a commitment at all levels. AIA projects have achieved success, in part, because they have built these practice guidelines into their structure.

Outcomes and Results of AIA Projects*

JEANNE PIETRZAK
JOHN KRALL

Although the AIA program was developed to ensure children's permanency, safety and well-being and improve the lives of families affected by substance abuse and/or HIV, the federal government granted the AIA grantees great latitude in determining how best to accomplish these ends for their distinct communities and clientele. Previous chapters have described the variety of approaches, services, and staffing that were adopted by AIA projects.

Although not funded as rigorous research projects, the Children's Bureau required each AIA project to conduct an independent outcome evaluation of their program services. Additionally, the Children's Bureau subsequently funded the National AIA Resource Center to collect and report on cross-site descriptive data, and later, on outcome data obtained from the projects.

This duty to evaluate has not been without its challenges. The AIA program evaluations, their corresponding measures and methodologies, are as diverse and unique as the projects themselves. AIA projects designed their evaluations to correspond to their own questions, interests, and purposes. On the other hand, collecting cross-site data required the Resource Center to coordinate with AIA demonstration projects to gather, integrate, interpret, and report the data. Although the Resource Center has attempted to collect basic longitudinal information on child development and well-being, child placement status, child safety, client satisfaction, parenting skills, and caregiver-child interaction, demographic data has been more forthcoming.

AIA service providers value the measure of their efforts and have a sincere desire and commitment to obtain a sense of the full picture. This chapter chronicles the successes and outcomes of various AIA projects, as evidenced by their own individual project evaluations, as well as the collective impact of the group of AIA demonstration projects.

* This chapter references AIA projects not previously mentioned in this monograph. For a description of these projects, please see the National AIA Resource Center web site: <http://socrates.berkeley.edu/~aiarc>.

Indicators of AIA Treatment Success

The comprehensive service demonstration projects have had far reaching effects on the lives of children and families served by AIA. The efforts of AIA projects have improved the permanency, safety, and well-being of children.

Permanency

AIA projects have made significant strides in facilitating and stabilizing the placements of children in safe and nurturing homes. The goal, in keeping with federal mandates and standards, has been to keep the children with their parents, whenever possible. When this is not possible, AIA projects work to expedite permanency for children in the homes of relatives or adoptive parents.

Expediting hospital discharges

Several AIA projects have been instrumental in reducing the length of time that infants board in hospitals, due to a lack of suitable residential placements, following medical clearance. For example, the New Start Project in Newark, New Jersey served nearly 2,000 children and families over a three-year period and reduced the average length of hospitalization after medical discharge by 77%, from an average of 45 days to ten days (as cited in Forsyth, 2000).

The Coordinated Intervention for Women and Children (CIWI, n.d.) project at the Yale Child Study Center in New Haven, Connecticut also achieved a significant reduction in the number of days that cocaine exposed infants spent in the hospital during the neonatal period (5 days vs. 9 days), and very few of those days were considered medically unnecessary. Furthermore, the cocaine exposed chil-

dren spent no longer in the hospital than a non-cocaine exposed comparison group.

Project Prevent in Atlanta also had success in reducing the length of hospital stays for infants. In the year before the inception of the project, 52 babies had boarded at Grady Hospital for a total of 1,002 days. Following the introduction of the project, the number of boarder babies dropped to approximately 30 per year (as cited in Forsyth, 2000).

In addition to expediting the hospital discharge of children born exposed to HIV and/or illicit substances, AIA projects reached out to HIV infected and/or substance abusing women during their pregnancies with considerable success. In analyzing the contrasts between women enrolled in the project while pregnant and those enrolled at childbirth, Project Prevent found differences that attest to the importance of early enrollment. From 1996-2000, infants of mothers who enrolled in Project Prevent in Atlanta while pregnant boarded in the hospital an average of 11 days, while infants of mothers referred postnatally boarded an average of 37 days. Infants of mothers enrolled while pregnant were also more likely to be discharged to their mothers (i.e., 78% versus 54%), rather than placed into foster care (i.e., 12% versus 26%). For the same years, the hospital boarding cost for the babies whose mothers had entered the project during pregnancy was \$187,500 – a substantial reduction from the almost \$2 million for boarding the infants whose mothers entered the project later. The savings for total medical cost for the care of the infant were even more substantial. For women enrolled in Project Prevent during the prenatal period, there was a 12:1 cost savings: \$3.24 million compared to \$16 million (Project Prevent, n.d.).

Achieving stability

Overall, AIA projects have been successful in maintaining children with their birth parents or, alternatively, facilitating the reunification of children initially placed in foster care with their parents. Evidence suggests the longer parents are enrolled in AIA projects, the greater the likelihood that children will remain with their biological mothers. The AIA cross-site evaluation found biological mothers who successfully completed AIA project services were substantially more likely to have their children living at home at termination than those who did not complete the services (68% vs. 38%) (National Abandoned Infants Assistance Resource Center, 2002).

The CIWI (n.d.) project found that of mothers who remained enrolled for more than three months, only 14% of their infants resided in foster care at termination, compared to 26% of children whose mothers remained in the project for less time. Similarly, mothers who remained in the project for more than three months were more likely (81% vs. 73%) to maintain the care of their children for the duration of the project. If a child was in foster care at intake but the birth mother remained in the project for greater than three months, she was more likely to have her child returned to her or a family member than if she left the project before the three months lapsed. CIWI found that initiating or maintaining substance abuse treatment was the most important indicator for gaining custody of one's child. Those who achieved this goal by six months were approximately twice as likely to have their children in their own care at termination (75% vs. 36%), one-third as likely to have their child placed in foster care (11% vs. 32%), and more likely to have their child returned to them from foster care.

The Drug-Exposed Infant Project achieved success in their attempts to achieve permanency for New York City foster children within their first year of placement. From 1998-2001, this project compared enrolled families with a matched control group. Birth mothers enrolled in the project started visiting their children sooner than those in the control group (41 vs. 55 days). The corresponding figures for the birth fathers demonstrate an even greater contrast (44 vs. 73 days). Not only did birth parents start visiting their children sooner; they also had significantly higher rates of child visitation thereafter than did those in the control group. The birth fathers enrolled in the project were significantly less likely to miss multiple scheduled visits in a given month than those in the control group. Within a year of placement, the Drug-Exposed Infant Project had reunited nine foster children with family members, as compared to none in the control group. Three years after placement, significantly more project children than control group children had achieved permanency – by a margin of 66% to 26%. As a result of these discharges from foster care, children's time in placement had averaged 10 months less than the control group's, yielding an estimated 3 year cost saving of \$12, 641 per project child (Leake and Watts Services, 2001).

Great Starts in Knoxville, Tennessee also had considerable success in reuniting and/or keeping families together. From October 1997-September 2001, only 29% of the index children were at home at intake with their parents without Child Protective Services involvement. At termination, this rate nearly doubled to 57%. Moreover, of the 45 index children who were included in a follow-up study of child custody outcomes, a total of 93% were no longer or had never been in state custody at least 6 months follow-

ing their mothers' participation in the Great Starts Program (Barton, Homer, & Magda, 2001).

In an attempt to maintain children with permanent caregivers and to keep children out of the child welfare system, several AIA projects assist families living with HIV to engage in voluntary permanency planning for their children. The intent of this service is to assure that the children of parents with HIV will continue to have safe and nurturing homes, in the event that their parents die, or become incapacitated. Family Options, in Chicago, provides social and legal service to HIV infected parents who choose to develop a future plan for care and custody of their children. Although nationally few families with HIV complete legal custody plans, 38% of the families served by Family Options put a legal plan into place between 1996 to 2000. In 32% of the cases, permanent guardianships were secured for new caregivers following their parents' deaths (Family Options, n.d.).

The Family Ties Project (2001) in Washington DC reported similar success. During the project period (1996 - 2000), 8 primary care giving clients died, but all 13 of the affected children had a permanency plan, which was implemented at the time of the parent's or caregiver's death.

Safety

AIA projects not only monitored the safety of the children enrolled in their projects, but also helped parents to change their circumstances and behavior, and acquire new skills to provide for their children's safety.

Reduction of substance abuse

Several AIA projects have achieved success in facilitating mothers' participation in drug treatment, as

well as supporting their recovery. Some of the AIA projects provide the treatment, whereas others coordinate and support this service through referral to other community agencies.

For example, Great Starts was able to assist women to achieve sobriety and improve their lives. Between October 1997 - September 2001, 43% of the clients who terminated from the project had completed the residential treatment project, and following treatment, clients generally exhibited fewer indicators of chemical dependency as tested by the Substance Abuse Subtle Screening Inventory (Barton, Homer, & Magda, 2001). The Bienvenidos project in Los Angeles experienced similar success. At the time of termination from their project, 84% of the clients who received drug treatment remained clean and sober (as cited in Forsyth, 2000).

From October 1996 - September 2000, TIES compared postpartum mothers enrolled in their project

IN THE CLIENT'S VOICE

"They helped me believe in myself, by believing in me. They had faith in me when I did not. My worker has been a great friend to me and my family. I thank her for that. I am looking forward to having my fourth child and he/she being a drug-free baby. I know that drugs were not the answer I was looking for. I just need to believe in myself."

with a matched group of women who were not. Both groups of newborns were exposed to the same drugs. The evaluation found that a higher percentage of TIES clients participated in drug treatment. Ninety-three percent of the women enrolled in the project attended drug treatment, compared to only 73% of the matched group. As with other outcomes, length in the project had a positive effect. On average, women who remained in the TIES project until their children were 18 months old showed improvement in addressing their substance abuse issues, from below expected to expected or better than expected outcomes (Fuger, Todd, Wilson, & McMann, 2000).

Reduction of child abuse and neglect

Many AIA projects have as a goal the elimination of child abuse and neglect with their project families and they are documenting successes. The CIWI (n.d.) project conducted a review of medical records at four major medical facilities in New Haven to ascertain child maltreatment rates among their clients. A group of children who were not exposed to drugs were included as a comparison group and matched to the CIWI children. Only one CIWI child (2%) had evidence of an episode of maltreat-

IN THE CLIENT'S VOICE

"(The program) gives mothers the chance to recover with their children. I've learned how to eat proper, sleep proper, and how to discipline my children without spanking them. (The program) has taught me to be a healthy, productive citizen of society."

ment, a rate that was identical to that found in the non-cocaine exposed comparison group.

The Oklahoma Infants Assistance Program (OIAP, n.d.) documented a substantial reduction in the potential of their clients to abuse their children. Between October 1998 - September 1999, scores on the Child Abuse Potential Inventory dropped from a mean of 195 at entry to a mean of 75 at project completion.

Improved parent-child interaction

Another common goal of AIA projects is to improve parents' abilities to provide supervision, support, and care for their children. Here again, AIA projects are registering success. From October 1996 - September 2000, the TIES project videotaped mother and child dyads and used the Parent-Child Early Relational Assessment to assess characteristics of the relationships between mothers and their infants in the project. This evaluation found that overall, "mother/infant pairs improved in their relational ability with time in the program" (Fuger, Todd, Wilson, & McMann, 2000). It was also discovered that TIES caregivers enrolled in the project while pregnant scored slightly higher than postpartum enrollees did, although the scores of both groups improved over time.

In addition, OIAP (n.d.) was able to demonstrate an increase in knowledge about child development and appropriate parenting. They found that the mean score on the Knowledge of Child Development Inventory rose from 37 to 46 for mothers who successfully completed project services.

Well-being

AIA projects have helped children and caregivers achieve health and welfare gains and generally improved the quality of their lives. Some of the more prominent outcomes are improved health and child development for the children, improved mental health for the mothers, and improved living conditions for the families.

Improved health outcomes

Involvement with AIA projects results in better health outcomes for children at birth, as well as postpartum. The greatest gains for infants were noted when engagement with the women began during pregnancy. For example, the babies of mothers who enrolled in Project Prevent (n.d.) during their pregnancy had a better chance (i.e., twice as many prenatal visits), and better outcomes (i.e., higher birth weight, lower incidence of positive toxicology screens) than those who enrolled postnatally.

The TIES project noted similar results. Infants of project participants who enrolled in TIES during their pregnancies had a mean birth weight of 3246 grams (approximately 7 pounds) and mean gestational age of approximately 39 weeks. In comparison, children of mothers enrolled postpartum had a mean birth weight of 2763 (approximately 6 pounds) and a gestational age of 38 weeks. Additionally, all but one of the infants of mothers enrolled postnatally was exposed to drugs in utero. However, the toxicology reports of infants of mothers enrolled in the TIES project while pregnant indicated that 34 of the 48 births (81%) were drug free at delivery (Fuger, Todd, Wilson, & McMann, 2000).

Association with an AIA project also made a difference in the maintenance of young children's health,

and with families addressing the children's health care issues more actively. For example, before the CIWI (n.d.) project began in New Haven, only 65% of children born to cocaine using mothers were completely immunized by one year of age; a level significantly lower than the rate of 79% among other children attending the same clinic. By 1999, 84% of the children in the project were fully immunized. Similarly, by one year of age 100% of the children enrolled in the Healthy Families project in Wichita, Kansas were immunized; compared with 58% in a control group. In addition, 90% of the families had an identified health care provider (Healthy Families, 2000).

Improved child development outcomes

AIA projects have been able to demonstrate advances in the developmental progress of enrolled infants. For example, the TIES project assessed enrolled infants at one month, six months, and twelve months of age, and noted statistically significant improvement in scores on the Bayley Scales of Infant Development over the time of involvement with the project. In addition, overall scores of infants enrolled in the TIES project were higher than a matched sample of similarly drug exposed infants (Fuger, Todd, Wilson, & McMann, 2000). Infants enrolled in the Best Beginnings project in New York City also scored higher on the Bayley than those in a control group, suggesting that their intervention had a positive effect on the infants' development (New York Society for the Prevention of Cruelty to Children, n.d.).

Improved maternal mental health

The vast majority of women enrolled in AIA projects suffer with significant depression, low self-esteem, and feelings of a lack of support. However, after participation in AIA projects women reported feeling

more supported and less depressed. For example, clients' reports from the Healthy Families (n.d.) project demonstrated that a majority of participants (60%) experienced increased support, and 67% of them reported developing increased coping skills and problem-solving abilities.

The TIES project found that approximately one-third of the mothers at intake perceived social supports to be unavailable to them. In addition, mothers assessed when their children were one month old usually considered professional helpers (including TIES staff) to be more helpful than natural supports. However, over an 11 month period, clients reported an increase in helpfulness from other relatives, presumably facilitated by the TIES project's work to strengthen the natural supports within the family (Fuger, Todd, Wilson, & McMann, 2000).

The Family-Centered Services' Home Visitation Project assessed the level of psychological distress among the women enrolled in their project and compared it to that of non-enrollees attending a medical clinic. They found that women in the project experienced a 33% reduction in psychological distress compared with only 14% in the comparison group (as cited in Forsyth, 2000). Likewise, Best Beginnings demonstrated that women in their project were less depressed after receiving services (New York Society for the Prevention of Cruelty to Children, n.d.).

OIAP (n.d.) also noted a decrease in depressive symptoms of women who completed their project, and lower scores on the Parenting Stress Index (PSI) at project completion, as compared to scores at intake. At Great Starts, following residential treatment and parent training in their nursery project,

clients also often exhibited less parental stress as tested by the PSI (Barton, Homer, & Magda, 2001).

Improved living conditions

The AIA projects assist families to access benefits, goods, and services that improve their lives and circumstances. Many of the projects are successful in assisting families with entitlement assistance, enrollment in educational or vocational projects, and obtaining safe and adequate housing.

Between enrollment and completion of the TIES project, the clients made great strides in addressing the challenges of securing suitable housing, as well as achieving long-term economic stability. After completing the 18 month project, 71% of the women had obtained safe and suitable housing, and 81% had attained adequate and stable income to support their families. Length of stay in the project was again positively associated with attaining these goals (Fuger, Todd, Wilson, & McMann, 2000).

Great Starts also demonstrated success in these areas. Their clients generally left the project with more sources of support than they had when they entered. Between October 1997 - September 2001, 64% of the Great Starts clients reported no source of income

IN THE CLIENT'S VOICE

"(My worker) helped me with my self-esteem. She made me see that I am not the only one struggling with recovery and I can do it."

at intake, but only 33% of the clients reported no income at termination (Barton, Homer & Magda, 2001).

The Whole is Larger than the Sum of Its Parts

AIAs projects, with their unique models of comprehensive, coordinated, and family-focused care, have been successful in addressing the complex needs and problems of families struggling with substance abuse and/or HIV and improving their lives in communities throughout the country. While challenges in serving these client families persist, AIA projects have demonstrated effective ways to address these hurdles.

Conclusion and Future Directions

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There is truth to the proverb, “The work will teach you how to do it.” Over a decade ago, the federal government created a demonstration program to respond to widespread abandonment and boarding of infants in hospitals due to the detrimental effects of substance abuse and HIV on families and communities. The goal of the AIA program was to prevent abandonment, promote the permanency, safety, and well-being of children, and improve the lives of families affected by HIV and/or substance abuse. This volume has chronicled the lessons learned from the work of AIA projects in over 10 years with over 17,000 individuals.

What the Families Taught Us

AIA projects work with clients who have experienced a significant degree of trauma, abuse, and deprivation in their lives. In addition to chemical dependency and/or HIV, they may very well have endured physical, sexual, and domestic abuse, poverty, homelessness, and/or psychiatric illness. Given the wide range of needs AIA clients have presented, it would be tempting for projects to assume significant responsibility for their well-being. Yet, when staff

took the time to listen to the families and to recognize their strengths, they came to appreciate the full impact of the caregiver’s role in project intervention. In order to engage the caregivers and keep them engaged, AIA projects learned at an early stage that they had to take their clinical lead from the caregivers themselves. This was a new way of working with this group of families, an approach unique to AIA projects serving high risk families in the early 90’s. In the beginning, most projects did not have sufficient experience in working with substance using mothers to place much confidence in their caregiving abilities. Gradually, awareness grew that mothers in AIA projects, as mothers everywhere, really wanted the best for their children and were willing to make changes on behalf of their children’s well-being.

Viewed from a family perspective framework, mothers were no longer seen as drug using women, but rather as mothers who cared about their children. The AIA projects recognized the strong bond parents had with their children and used this attachment as an opportunity to intervene with the families. The projects began to collaborate with families, and rather than prescribing goals and strictly requiring

that they be followed in order to remain in the project, staff began supporting clients in setting their own goals. Once this was established, client commitment to continue project involvement and ultimately, to individual behavioral change, was possible.

This change in attitude was a difficult task for both the caregivers and the project staff. For families, issues of mistrust of systems, resistance, or confounding life situations interfered with collaborative work relationships. Equally, project staff struggled to let go of the need to be in control and to be flexible enough to apply changing clinical practices, based upon a growing supportive literature about therapeutic relationships. AIA staff had to strive to gain the trust and acceptance of the families. Helping clients as opposed to judging them, listening to them and respecting their goals, developing assessments that make sense to them, and adopting an approach that is flexible and adaptable, helped to reduce the barriers to engagement. AIA interventions were “client-driven” and based on families’ strengths, capabilities, and choices.

If families were going to experience improved outcomes, though, the burden of effort was clearly on the project. This process was time consuming, took repeated efforts, and required a strong belief in a family-focused system of change. As one project administrator reported, “Staff...have been very adept at communicating genuine positive regard for both parents and children without becoming enmeshed or creating dependence” (National Abandoned Infants Assistance Resource Center, 2000).

Programmatically, effective staff has been an essential element in successful AIA program development and service provision. The development of staff with the

IN THE CLIENT'S VOICE

“(The program) helped me with everything as far as getting back into society again after being chemically dependent with children. A lot of times, I called (worker) just because. . . just because, because I didn't know what to do with myself in that particular time and just that support. . . I mean it is more than just the diapers and the rides to and from the pediatrician, rides to and from the store and things like that—it's more than that. It's just the support of having someone to talk to that understands. I don't know what I would have done without this program. I would have been lost.”

empathy, knowledge, and ability to work with families that require intensive and sustained services is no easy task. Careful recruitment, initial and continual training, adequate compensation and supportive supervision have all been elements integrated into AIA projects. Other programmatic features, such as the use of peer workers and interdisciplinary teams, culturally sensitive services, and home-based interventions, also proved to be effective strategies with these families.

What the Children Taught Us

Addressing the adult family members’ needs is not the sum of AIA’s therapeutic experience. The children in AIA projects are vulnerable to the same life stressors as their caregivers, and are at risk for child

abuse and neglect because of the conditions in their environment and the lifestyles of their family. For these reasons, child safety, permanency, and well-being had to become AIA's overriding themes. Yet, each project learned that efforts to ameliorate adverse conditions could only be accomplished through the family.

Finding a balance between addressing the child's needs with the needs of the families has been, and continues to be, an important task for AIA providers. AIA projects responded to this balancing act by informing families that their actions affect the development of their children. Caregiver education and developmental monitoring are critical areas of clinical work in AIA projects. In addition to prenatal drug exposure (PDE), the "abandoned" children in AIA projects are also at higher risk for HIV exposure, since many of the women served by AIA projects are HIV infected. Further, AIA projects had to counter the alarm in the late '80's and early '90's created by sensationalist and erroneous media reports of the so-called "crack baby" crisis and the compromised the developmental and outcome potential of PDE children.

The long-term effects upon PDE children over the years have generally proven the dire predictions wrong. According to AIA experience, these children were not always referred to special education when they enrolled in the public school system, nor were they all destined to exhibit severe behavior problems that taxed the public school system. That is not to say that children with PDE or HIV were free of developmental concerns. Because of several confounding conditions AIA children experience besides PDE (e.g., poverty and chaotic parental lifestyles) their cognitive, speech and language, and behavioral

performance was sometimes compromised. In fact, AIA projects were aware of the potential adverse impact on development for this group of children and routinely examined, assessed, and intervened on their behalf. They found that early intervention efforts improved child outcomes or minimized negative effects. In general, this meant that AIA projects focused on ongoing assessment, consistent developmental follow-up, parenting skills improvement, and strengthening the parent-child interaction as part of their prevention and intervention efforts. AIA projects also kept the families engaged in programmatic efforts, since this ensured that families, at a minimum, would attend well-child clinic appointments and keep their child's immunizations current.

More importantly, there is a growing body of evidence about the resiliency of children. AIA projects have been rewarded by seeing how individual children succeed "against all odds" (Werner & Smith, 1989), somehow not only "making it" in the world, but actually thriving in it. These children have learned to cope and make adaptations to the adverse demands of their environment. Better coping, in turn, leads to improved developmental learning capacity. AIA projects with strong developmental components attempt to strengthen these coping behaviors in children by helping them regulate their behavior, improve their problem-solving skills, manage change and transitions, and regulate mood and affect. They also work with the families to enhance their children's development.

It was also recognized that no single organization could provide all the varied services required by families with multiple problems and needs. Therefore, AIA projects adopted a holistic and systems approach to serving families and developed collaborative rela-

tionships with a number of community agencies in the health, mental health, criminal justice, judicial and social services fields. AIA projects discovered that the coordination and integration of systems yielded greater utilization by the clients, as well as positive outcomes for them.

Many AIA families are able to raise their own children, whereas other families conclude that the best recourse for their children is placement out of the

IN THE CLIENT'S VOICE

"I was apprehensive about any more workers being involved in my life. As time went on I began to trust and rely on (my worker) for a number of things. She became someone I could talk to and tell my everyday hassles to. Even when I took my vacations from everyone and almost gave up on everything, she was always encouraging and supportive. As time for me to graduate moves closer I am saddened, because aside from all the help (the program) has given myself and child, I will miss (my worker) and the other women most of all. I have been blessed to be involved with such a kind and beautiful group of women. I hope that other women in these same circumstances will try to hook up with a program in your area. It could be your only friendly lifeline to get you back on track and back to a better life."

home, with extended family or other caregivers. Families living with HIV are challenged further to face the emotionally taxing process of planning for the future care and custody of their children. AIA projects have been successful in bringing families to the point where they can consider and act on these issues, and thereby plan for their children's future and welfare.

Projects learned that there are no quick fixes in this line of work. The nature of the work with the families and within the community is challenging, laborious, and long-term and requires significant commitment and persistence. In the final analysis, however, AIA projects found that families confronting HIV and/or substance abuse often have the capacity to adopt healthy new skills, attitudes and behaviors and act in the best interest of their children with sufficient support, assistance, and acceptance of skilled professionals.

Future Directions

The work done by AIA projects in improving services to families affected by substance abuse and/or HIV also suggests future directions for public policy. Since most AIA clients receive some form of public benefits and the majority is involved with the child protection system, both clients and the AIA projects are greatly affected by recent shifts in federal policies. In particular, The Personal Responsibility and Work Opportunity Reconciliation Act (PRWORA) of 1996 (P.L. 104-193) and The Adoption and Safe Families Act (ASFA) of 1997 (P.L. 105-89) set specific time limits, with certain exceptions, on the receipt of public welfare benefits and on length of stay in foster care.

However, time limits are often difficult for families coping with issues like substance abuse, health problems and working toward self-sufficiency. As AIA projects have noted, flexibility and adaptability are critical features of projects and policies affecting these families. As new public policies are implemented, these features should be recognized and highlighted to meet better the diverse needs of families.

For example, the attempt to shift people off public benefits, as exemplified by the PRWORA, needs to be coupled with services and resources that facilitate the ability to work, specifically job training and childcare. AIA clients are primarily families headed by a single woman of color, who has had little education or work experience. To fulfill the promise of PRWORA, education and training are needed for these mothers to be able to compete for available jobs, to earn a living wage, and to protect them and their children from falling through the cracks or living in extreme poverty. Additionally, a parent obviously cannot leave a child without proper care and supervision to report to work. Safe, stable, and free or affordable childcare is a necessity for parents who work.

In addition, shifting from welfare to work must be done in a way that continues to protect medical and housing benefits. Unfortunately, an unintended side effect of PRWORA has been the loss of Medicaid to eligible recipients when welfare benefits (generally, Temporary Assistance to Needy Families) are discontinued. This national problem is exemplified by the fact that New York City and State recently agreed to “pay back the medical expenses and restore the health care coverage of thousands of poor city families who were wrongly cut from Medicaid when they were dropped from the welfare rolls.” In 2000, the

Clinton administration “ordered all states to identify people who had been improperly cut from Medicaid and to restore their benefits” (Bernstein, 2001).

Three-quarters of the families served by AIA projects are involved with the child protection system. Most of these families face a multiplicity of problems that will need considerable time to resolve. Given the new time limits set by ASFA, innovative policies that facilitate permanency for children, preferably within the family of origin, need to be adopted.

In the context of voluntary permanency planning, on the state and federal levels, planning options need to be expanded and developed. No one voluntary permanency planning tool is a panacea; families’ needs are complex and varied. The availability of a variety of tools provides a better scenario to adapt to individual families and to provide permanency to children. For example, standby guardianship, which is used so effectively by many of the existing AIA projects, is only available in 19 states. The availability of standby guardianship and other voluntary permanency planning options would greatly benefit many of the families served by these AIA projects. Illinois serves as a model of the progressive expansion of voluntary permanency planning tools - standby guardianship has been available since 1991, and standby adoption legislation, which was sponsored and supported by local AIA demonstration projects, was passed in 2000 and, provides a unique tool for permanence for children whose parents have a life threatening illness, was passed in 2000. At present, Illinois is the only state with standby adoption.

Another emerging area of practice is infant mental health; defined as “the state of emotional and social competence in young children who are developing

appropriately within the interrelated contexts of biology, relationships, and culture” (Zeanah & Zeanah, 2001, p. 14). A healthy relationship between caregiver and child has been identified as the key to this concept while supporting it is recognized as a primary programmatic focus. Through close and secure interpersonal relationships, the child is better able to feel and learn, and explore the environment. The momentum for attending to infants’ mental health is gaining strength and several states have developed coalitions and workgroups that have developed programming and strategic plans to address this issue (Knitzer, 2000). With their extensive experience working with children at environmental and biological risk, AIA projects are poised to lend their expertise to this movement and to incorporate the findings from this new field.

Since 1988, the AIA demonstration projects have had far reaching effects on the lives of children. Mothers who completed services were more likely to have their children living at home than mothers who did not. Generally, parents are better able to care for their children because of AIA projects. Evaluations have shown that the AIA projects have increased the permanence and stability of caregiving; been instrumental in expediting hospital discharges; monitored child safety and taught parents new child safety skills; facilitated participation in drug treatment programs; worked to eliminate child abuse and neglect within project families; helped to improve parent-child interactions; improved the well-being of the child and family; improved health outcomes; improved child development outcomes; improved maternal mental health; and improved living conditions for families.

A large number of families continue to need assistance and it is unlikely that this will diminish in the future. In fact, the number of women infected with HIV continues to increase steadily and substance abuse problems continue to plague a large number of families. In addition, a recent study commissioned by the U.S. Department of Health and Human Services (2001) found that the number of boarder babies and abandoned infants had actually increased in both number and geographic spread throughout the country. The successes of the AIA program, coupled with the continuing need for services, demonstrate that funding for innovative programs that provide child welfare services for children and families affected by substance abuse and/or HIV is a necessity.

Investment in programs like AIA will likely be much more cost effective than dealing with the financial, societal, and emotional costs of families disrupted by substance abuse and/or HIV. As we look forward to the next decade of service to families and children affected by substance abuse and/or HIV infection, we need to continue the commitment to fund innovative service programs and to develop new and flexible policies that meet the needs of these families, improve their lives, and promote the safety, permanency, and well-being of their children.

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