

DC Family Policy Seminar

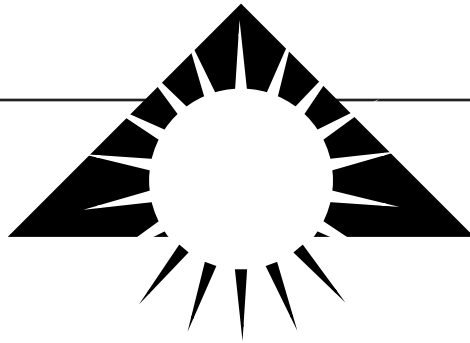
“Substance Abuse Prevention and Treatment Programs: A Family Approach”



BACKGROUND BRIEFING REPORT

The DC Family Policy Seminar aims to provide accurate, relevant, non-partisan, timely information and policy options concerning issues affecting children and families to District policymakers.

The DC Family Policy Seminar is part of the National Network of State Family Policy Seminars, a project of the Family Impact Seminar, American Association for Marriage and Family Therapy Research and Education Foundation.



DC Family Policy Seminar

“Substance Abuse Prevention and Treatment Programs: A Family Approach”

BACKGROUND BRIEFING REPORT

By

Kerry Whitacre, Mark Rom, and Amy Scott

Georgetown University
Graduate Public Policy Program

February 1995

This report provides a brief introduction to the issues addressed by the DC Family Policy Seminar on February 10, 1995. The author wishes to thank the numerous individuals in the government of the District of Columbia and in local and national organizations for contributing their time and efforts to this seminar. Special thanks are also given to Mark Rom, Director of the DC Family Policy Seminar, to the staff of the National Center for Education in Maternal and Child Health, and to Valerie Gwinner, Tobi Printz, Amy Scott, and Shelley Stark for their invaluable assistance in hosting this seminar.

“Community Substance Abuse Prevention and Treatment Programs: A Family Approach”

This seminar is the fifth in a series designed to bring a family focus to policymaking. The panel features four speakers:

Johanna Ferman, Chief Executive Officer and Medical Director of the Center for Mental Health, Inc., 2639 Connecticut Avenue, NW, Second Floor, Washington, DC 20008, (202) 462-9129.

Aminifu Harvey, Executive Director, Maat Center for Human and Organizational Enhancement, 5113 Georgia Avenue NW, Washington, DC 20011, (202) 882-9744, fax (202) 882-9747.

Loretta Tate, Director, Fighting Back Initiative Marshall Heights Community Development Organization, 3732 Minnesota Avenue NE, Washington, DC 20019, (202) 397-7300, fax (202) 397-7882.

Joseph Wright, President, Washington Area Council on Alcohol and Drug Abuse, 1707 L Street NW, Suite 200, Washington, DC 20036, (202) 682-1700, fax (202) 682-1710.

This seminar focuses directly on the role of the family in the prevention and treatment of substance abuse. This background report summarizes the essentials on several topics. First, it provides an introduction to the role of the family in substance abuse. Next, it briefly describes the key issues involved in community and family-oriented prevention and treatment strategies for substance abuse. An annotated list of prevention and treatment programs and organizations completes the report.

Introduction

This briefing report focuses on alcohol and illicit drug addiction prevention and treatment programs that incorporate a “family perspective.” The Institute for Health Policy defines substance abuse as the “patterns of [alcohol and illicit substance] use that result in health consequences or impairment in social and psychological functioning” (1993). Substance abuse is a nationwide problem that creates medical, legal, and financial costs for the abusers as well as for our society as a whole. The fact that substance abuse is so often intertwined with other social ills such as violence and AIDS only compounds the importance of resolving the problems and the difficulties.

The problems of substance abuse affect not just individuals but also their families. A family approach thus would recognize that substance abuse programs need to help the family prevent or reduce substance abuse by fathers, mothers, and children while at the same time protecting other family members from those who do misuse alcohol and other drugs. A family approach to substance abuse as a result might “strive to keep the family together through providing preventative and treatment strategies which assure the child is protected and safe while the mother (or father) works on improving her capacity to be a parent and enrolls in drug treatment (Ooms and Herendeen, *Drugs*, 2).

Traditionally, policymakers have not regarded substance abuse primarily as a family issue. Instead, our nation’s policies have viewed

substance abuse as either a criminal or medical issue affecting individuals. By seeing more clearly the role of the family in substance abuse, perhaps more effective strategies for preventing and treating the misuse of alcohol and other illicit drugs can be developed.

Role of the Family

This briefing report will examine how substance abuse affects families, and, in turn, how families influence substance abuse. Special attention will be paid to the challenges of dealing with pregnant women, substance abusing parents, and adolescent substance abusers.

Influence of the Family. The factors that determine whether an individual will become a substance abuser are strongly influenced by that individual's family. Children are more likely to abuse alcohol and other drugs if their parents do (Hawkins, et al., 11). If one spouse is more likely to be an abuser, the other one is, too. And, while substance use is linked to social factors, substance "abuse is generally more strongly linked with individual and family factors leading to the need to self-medicate against internal distress or seek drug-induced highs. The distress is commonly a result of dysfunctional family patterns and dynamics and psychological and emotional factors such as poor self-esteem, school failure and learning disability, and poor social controls" (Ooms and Herendeen, 4). In addition, growing evidence indicates that there may be a genetic component to alcohol and perhaps other drug abuse (Ooms and Herendeen, 4). Most individuals who abuse drugs begin doing so during adolescence. Families, unfortunately, do not always shelter their adolescents from the risks of substance abuse. Indeed, the family itself may create risk factors. For adolescents, the family factors that are often associated with substance abuse include the parent's own substance abuse problem, parenting styles, patterns of communication and conflict, and other family dysfunction. Substance abuse may also be due to the inability of some families to renegotiate relationships necessitated

by an adolescent's transition to adulthood. Adolescents also seem to be especially vulnerable to family stress such as death, illness, divorce, job loss, and relocation (Ooms and Herendeen, 4). It is tragic—but true—that a person's risk of substance abuse appears tied to that person's family.

Impact on the Family. Substance abuse is widespread in families. Since substance abuse is highest among the population under age 45, a majority of abusers may already be parents, parents-to-be (or of childbearing age), or minors living with their parents (Schottenfeld et al., 81). Substance abuse can place a tremendous burden on all family members—infants, children, adolescents, spouses, and grandparents.

Substance abuse by pregnant women can be especially damaging to the family. A pregnant woman who abuses substances risks exposing her fetus to a number of potential health problems, including premature birth, fetal alcohol syndrome and fetal alcohol effects, low birthweight, small crania, neonatal seizures, cerebral infarctions, and rare urogenital birth defects. In addition, it has been reported that cocaine-exposed babies are especially difficult to nurture (Office for Substance Abuse Prevention, iii). The most severe result of drug or alcohol abuse is fetal death. It should be noted that a mother's substance abuse does not necessarily doom a baby; normal, healthy babies have been born to substance-abusing mothers (Office for Substance Abuse Prevention, 2). Still, "drug exposure also interacts with drug-related problems of the mother, which can include poor health, particularly sexually transmitted diseases and malnutrition, and refusal or inability to seek prenatal care" (Office for Substance Abuse Prevention, 1).

Infants who were exposed to alcohol or illicit drugs in the womb or during breastfeeding often fall prey to a number of health problems that affect their ability to develop and communicate. On the one hand, infants who have been exposed to drugs have greater health problems but are less able to communicate these problems to their

mothers. On the other hand, substance abuse “interferes with the mother’s capability for, or interest in, responding to her infant’s needs and building successful mother-infant communication” (Office for Substance Abuse Prevention, 2). Many babies who have been exposed to heavy substance abuse stay in the hospital for protracted periods of time and may spend their early years in the child welfare system.

In addition, substance abuse often affects the relationship between spouses. The Institute of Health Policy estimates that 20 percent of men and 25 percent of women attribute their marital problems to substance use. One-third of women who are divorced or separated were, at one time, married to a substance abuser.

Families who have problems with alcohol and other drugs often experience a number of concurrent problems—including violence, child abuse, and neglect. The children in such families are at increased risk for also becoming substance abusers. Children from such families often suffer from emotional and developmental problems that inhibit success in school and acceptance by peers.

Substance abuse in families exerts a large financial drain on households (Institute of Health Policy, 40). Substance abuse imposes financial burdens by reducing the family’s ability to earn money, by shifting spending from healthy to unhealthy expenditures (i.e., from food, shelter, and clothing to alcohol and other drugs), and by increasing the need for medical services.

Major Policy Issues

It is clear that substance abuse places a great burden on individuals, families, communities, and society as a whole. There is little consensus, however, regarding the best way to reduce substance abuse. Much of the debate concerns three questions. Is substance abuse a disease? Is substance abuse influenced largely by social factors? Or is substance abuse attributable mainly to an individual’s lack of will or personal responsibility?

How one answers these questions often dictates the type of policy one supports. To the extent that substance abuse is a disease, then medical prevention and treatment policies make sense. Alternatively, if social factors dominate, then programs to change the social environment to reduce or prevent substance abuse would be beneficial. But if substance abuse is a matter of personal choice, then law enforcement strategies to reduce the demand for drugs through punishment, or psychological methods that reduce demand for drugs through counseling, might be more effective.

The debate over which strategies are effective and appropriate for preventing or treating substance abuse becomes even more complex when applied to families. Just as substance abuse affects the family, programs to prevent or treat abuse also affect the family. Consider, for example, the issue of prenatal substance abuse. A few states have criminalized prenatal substance abuse by classifying it as child abuse or other drug-related crime. Such policies can create good consequences by protecting the fetus from the damage of substance abuse. This good, however, may be outweighed by unintended consequences. Pregnant women who are substance abusers may be afraid to seek prenatal care because they are afraid their children will be taken away or they will be arrested. Imprisoning the woman, moreover, may leave her other children with a more abusive parent (or no parent at all). The conditions in jails or psychiatric hospitals can sometimes be injurious to fetal and child health (Office of Substance Abuse Prevention, 7).

Another policy response to the problem has permitted public housing agencies to evict families in which individuals are suspected of substance abuse. While these evictions may represent an understandable desire to protect other residents, the evictions may upset the already fragile balance among children’s rights, parents’ rights, and the government’s responsibility to protect children. The evicted families—especially their children—may, indeed, become more susceptible to further

substance abuse and developmental problems. Such policies may only serve to weaken families.

Prevention Programs

Education and prevention programs and strategies target the general population, or specified at-risk groups, with the goal of abstinence (or at least delay) from initial substance use. Most prevention programs attempt to target youths before they begin experimenting with alcohol and other illicit drugs. The need for and difficulties of these programs are great. A report by the Institute of Health Policy states that, by the eighth grade, “70 percent of (American) youth report having tried alcohol, 10 percent have tried marijuana and 2 percent cocaine, and 44 percent have smoked cigarettes. By the 12th grade, about 88 percent have used alcohol, 37 percent have used marijuana and 8 percent cocaine, and 63 percent have smoked cigarettes” (Institute for Health Policy, 9).

One of the objectives of prevention programs is to foster drug-free families. The purpose of these programs, as described by Hawkins, et al. (p.88), is to:

“Provide parents with information about drug use and risk factors so they can be better prepared to work on preventing drug use by family members;

Empower parents to set a clear family position on drug use by family members;

Provide parents and children with the skills to refuse offers to use drugs; and

Increase family bonding both by reducing conflict and by increasing children’s involvement in positive family activities.”

There are several points at which substance abuse prevention programs might target families or engage families to assist in the program. These points will be considered in turn.

Prenatal Programs. These programs typically include education concerning the impact of substance abuse on fetal development. Prenatal

programs show great promise because pregnancy is an opportune time to prevent or change negative behaviors of mothers (and perhaps fathers) while they are likely to be more conscious of their nutrition and substance use. Yet, “the major problem [with prenatal programs] is that substance-abusing women often are in a poor health state prior to pregnancy and do not seek prenatal care until complications occur or they are late in pregnancy” (Hawkins, et al., 57). For these programs to fulfill their promise, greater outreach efforts are needed to identify and recruit substance-abusing women.

Parent Training. After the child is born, parents need to be educated and supported to promote family attachment and positive child-parent interaction (Hawkins, et al., 50). Persons who abuse substances need more assistance (such as outreach services, home visits, clinic contact, psychological services, and nutritional services) than do persons who are drug-free. Babies born to substance-abusing mothers often are more difficult to care for because their body language is unreliable (i.e., muted and confusing). A parent’s emotional distress—whether related to education, interpersonal relations, or finances—can increase their children’s risk for problems such as school failure or psychopathology. Parent-child interaction and attachment also affect the child’s development and can increase risk factors for substance abuse. “Establishing positive, growth-promoting parent-infant communication is the most important foundation for emotional and intellectual development of the child (Hawkins, et al., 5).

Early development is vital for later social and cognitive growth and adjustment. Normal development involves reading readiness and development of self-control. Numerous studies suggest that abuse and delinquency start early in a child’s life. Early school failure is difficult to overcome and can lead to serious problems later, including substance abuse. Young children need to be taught life skills that are culturally and developmentally appropriate. Such prevention programs should “promote language skills; increase clarity of rules,

consistency of enforcement of rules and consequences for behavior; and increase the child's self-management skills" (Hawkins, et al., 74).

Parents are a major influence in the development of their children, regardless of whether they make conscious efforts to be effective parents. Many of the risk factors for drug abuse are directly related to family, including poor family management practices, a family history of alcoholism, and permissive parental attitudes toward drug use. Family bonding is a key protective factor that can be strengthened by improving family communication and family management practices—interventions directed toward parents have also been found to reduce other risk factors related to drug abuse, such as early aggressive behavior, poor school adjustment, and delinquent behavior" (Hawkins, et al., 86).

Schools. Schools provide another common target point for prevention programs. A majority of substance abuse programs involve school organizations, management, and curricula. However, few school programs involve parents and other family members directly. Some schools attempt to create a "community of shared purpose" to foster parental involvement in their children's education. Some curricula that appear to have some success have involved parents, families, and the extended community in working together to establish anti-substance norms. Many curricula include education about the risks of substance abuse and unplanned pregnancies, HIV/AIDS, and other sexually transmitted diseases due to decreased inhibitions and high-risk behaviors (such as dirty/shared needles). These programs might be more successful if parents became more involved and could reinforce the prevention messages at home.

The Community. Community prevention programs attempt to mobilize all of the institutions in a neighborhood—families, schools, businesses, churches, police—to reduce the social risk factors for substance abuse. These prevention programs thus rely on building community norms, values,

and policies so that substance abuse is stigmatized and "going straight" is honored. Community approaches hope to build success by involving a wide spectrum of individuals and institutions.

A study by the U.S. General Accounting Office (1992) found that the most promising programs started with youth ages 10–13 years—before prevention efforts compete with substance-abusing peers. The study found that the most promising prevention programs had the following components:

1. A comprehensive strategy;
2. An indirect approach to substance abuse prevention;
3. The goal of empowering youth;
4. A participatory approach
5. A culturally sensitive orientation; and
6. Structured activities

These programs reported a number of common problems, including maintaining continuity with participants, coordinating services, providing accessible services, obtaining funding, attracting leadership and staff, and conducting evaluation (General Accounting Office, 3).

Treatment Strategies

Early intervention and treatment programs are aimed at individual users who are in danger of becoming addicted and at those who are already substance abusers. Treatment programs traditionally have been aimed at individuals outside of their family roles. Thus, substance-abusing individuals are removed from the family to receive treatment, and when treatment is completed, they are returned to the family. The family, as a whole, receives little guidance. These individual treatment programs are often expensive and only moderately successful (Hawkins, et al., 6).

Treatment models typically adopt medical, behavioral, or social perspectives (Schottenfeld, et al., 83–84). Treatment can involve pharmacological, psychological, and structural interventions—all with varied success. A relatively new model and

method of treatment incorporates a family focus. When a substance abuser is also a parent, the parental role must be taken into account during treatment. Treatment for severely addicted parents must take a multifaceted approach that considers the parent/child developmental needs. One such program provides parent training in addition to substance abuse counseling. Specialized programs, family support services, on-site child care, child development services, and child protection services are all aspects of a family-oriented treatment program that protects the child while enabling a parent to recover from addiction (Schottenfeld, et al., 87–90).

For families with older children, family therapy is increasingly being used as a treatment strategy. One of the most difficult parts of the treatment regimen involves getting the substance abuser to come in for treatment. The next hardest part is to recruit other family members to participate in treatment (Schippers, et al., 210). Families can be involved in “dis-enabling” the abuser (Thomas and Ager, 10). Community Reinforcement Training for Families is a training program designed to teach family members how to encourage an abuser to stop drinking and to enter counseling (Sisson and Azrin, 38).

Treatment for pregnant substance abusers is not available in most communities. Limited funding and the categorical nature of funding prevents the development of adequate facilities to offer help to pregnant women and their families. Proponents of treatment emphasize that treatment programs for substance-abusing pregnant women and mothers of small children should be different from programs for other women or men. Because of the unique needs of the population of pregnant and parenting substance abusers, treatment should be individualized and should focus on the needs of the mother and her fetus. Some women will need to be removed from their current environment and others will need only minor interventions. The problem is in matching treatments with individuals (Brown, 11–12). Involving the whole family in

treatment is especially vital when dealing with “significant others” who also are likely to be substance abusers. “Children of women in treatment are integral parts of the women’s lives and that if residential care is planned for a woman, her children may need to be housed with her or otherwise carefully provided for” (Brown, 13). Follow-up care after any substance abuse treatment program is also very important in order to reduce the risk of relapse.

Treatment for adolescents requires a system of assessment and diagnostic tools for treatment referral. Many families go through denial and resistance when a member of the family has a substance abuse problem. Until the 1980s, few substance abuse treatment programs targeted adolescents. A variety of types of programs now exist, including telephone hotlines, community outreach programs, hospital emergency room detoxification services, outpatient clinics, day treatment, inpatient intermediate care programs, Therapeutic Community residential programs, halfway house programs, and community-based, volunteer self-help groups that target teenagers (Ooms and Herendeen, *Adolescents*, 7). Such programs in various settings help adolescents and their families receive “individual counseling, psychological testing, drug education, remedial schooling, family therapy, group therapy, peer support, and multiple family therapy” (Ooms and Herendeen, 7).

Principles and Strategies for Family Treatment Programs

The DC Family Policy Seminar has developed a list of key model program principles and strategies for successful family-oriented programs:

- The program must be family-focused, with some services designed to focus on the parent’s needs, others on the child’s medical and developmental needs, and others on the parent-child relationship. Even when it is necessary to remove the child from the

parent's care at least temporarily, the parent still needs services to help regain the child (or release the child for adoption) The need is also great for preventive services to help the mother avoid further exposing any children to drugs.

- Programs must operate with a broad definition of family. Relatives (usually the grandmother) often share responsibility for the child, or will take over the care totally when the parent is incapable of doing so. These caregiving relatives need to be involved in services to help both the parent and child. "Significant others" living with the mother or father of the child may also need to be involved.
- Services also need to be provided for foster parents, both to enable them to meet the special needs of drug-exposed babies and children and to help encourage mutually supportive relationships between the biological parent(s) and foster parent.
- Programs must be flexible to offer a range of services with varying levels of intensity, since some parents are not as seriously troubled or in need as others.
- Close coordination must take place between the various agencies and service systems serving this population (namely, health care, protective services, social services, and the courts). Some communities have accomplished this through establishing community coordinating councils with broad representation from a range of services in order to forge various interservice agreements. The lead program must develop good liaisons with community agencies that can provide parents with referrals to specific services such as employment, training, and housing services.
- Access to services must be simplified. A highly desirable program model is the "one-stop" services center, where many services are located under one roof.
- Programs should include both home-based and center-based components. Home-based components are needed to make a thorough assessment of the patterns of substance abuse and the relative risk to the child; explore the resources available within the extended family and community; and develop supportive relationships in order to benefit from these resources. Center-based components are needed to draw these parents out of their social isolation, to introduce structure and routine into their lives, and to provide peer support and a familiar, secure place to turn during troubled times.
- Traditional addiction treatment services need to be modified to meet the needs and child care responsibilities of chemically addicted mothers, and to take into account the fact that many live in drug-ridden communities. Some believe this implies less emphasis on the disease model and goal of total abstinence, and a more realistic acceptance of the tendency to relapse.
- Training professionals to work together as a team in these programs is very important. They need to improve their knowledge of the complex medical, social, legal, and ethical issues involved in caring for substance-abusing mothers and their children, and to develop common language, perspective, and goals so they can plan and carry out coordinated interventions. (Ooms and Herendeen, *Drugs*, 12–13).

The D.C. Family Policy Seminar is coordinated by Mark Rom, Assistant Professor, Georgetown Graduate Public Policy Program (GPPP), 3600 N Street N.W., Washington, DC 20007-2670. (202) 687-7033; fax (202) 687-5544.

For additional information about the D.C. Family Policy Seminar, or to order copies of the following briefing reports, please contact Amy Scott at (202) 687-8477, ext. 3:

“Family Friendly” Welfare Reform, November 1994
“Preventing Family Violence,” September 1994
“Preventing Adolescent Violence,” May 1994
“Preventing Teen Pregnancies,” December 1993

Resources

Substance Use Treatment and Prevention in the District of Columbia

Substance abuse is a serious problem in the District of Columbia. According to a comprehensive survey conducted by the National Institute on Drug Abuse, 40% of D.C. metropolitan area residents have taken one or more illicit drugs in their life time and 12 percent have used illicit drugs within the last year. (Squires, 8). More ominously, large proportions of those arrested or treated in hospital emergency rooms are under the influence of alcohol or other drugs. For example, in 1993 over 40 percent of adult arrestees in the District tested positive for cocaine; over 40 percent of the juvenile arrestees tested positive for marijuana (the prevalence of alcohol use is not reported) (Mundell, 1994). While this substance abuse did not necessarily cause the encounter with the police or the hospital, it nonetheless shows how common it is among those in trouble.

Substance abuse prevention and treatment programs also face serious problems in the District. The need for prevention and the demands for treatment are enormous. Yet the District's fiscal crisis guarantees that the D.C. government will be under pressure to further cut its substance abuse programs. It will also be difficult to coordinate any budget cuts so that the most needed and effective programs are best protected. For example, no single District office has responsibility for prevention programs.

Still, there are many reasons for hope. A wide variety of public and private organizations—and many talented and dedicated individuals—in the District offer substance abuse prevention and treatment programs. While there is no complete

directory of all these efforts, an annotated list of many programs and organizations involved in prevention and treatment concludes this section. A description of the activities and recommendations of representatives from four of these organizations—the Center for Mental Health, the Maat Center for Human and Organizational Enhancement, the Marshall Heights Community Development Initiative, and the Washington Area Council on Alcoholism and Drug Abuse—will appear in the D.C. Family Policy Seminar's "Highlights" to be published after the February 10, 1995 meeting.

The D.C. government, for its part, offers (through Department of Human Services, Commission of Public Health, Alcohol and Drug Abuse Administration contracts) approximately 30 treatment programs for alcohol and drug users. These programs offer medical, psychological, educational, and vocational services (Indices, 239). At the same time, the District conducts prevention programs through the Department of Public and Assisted Housing, the Police Department, the Commission of Public Health, and the Commission of Social Services.

Substance Abuse Prevention and Treatment Programs: A Family Approach

This section contains a list of the substance abuse prevention or treatment programs we have identified that are operating within the District. It is not meant to be exhaustive. Brief program descriptions, as identified by the organizations, are attached.

“A Chance at Life” program of the Washington Area Council on Alcoholism & Drug Abuse

A Chance at Life serves African-American youth ages 10-17 years and their families in prevention and intervention of alcohol and drug abuse. This program includes: “A Chance at Life” workshops, parent empowerment workshops, a council of elders, support groups and technical assistance. The goal of this program is to identify and reduce factors in the individual, parents and extended family, school, peer group and neighborhood that place youth at risk.

Contact: Mr. Ray Whitfield (301) 773-6953

Alanon / Alateen

Alanon and Alateen are programs associated with Alcoholics Anonymous of D.C. Alanon provides group meetings for the families and friends of alcoholics, while Alateen offers group sessions for the children of alcoholics. These meetings allow for the discussion of concerns and difficulties in an atmosphere of understanding.

Contact: (202) 882-1334

“Family Health Program” of the Center for Mental Health, Inc.

The “Family Health Program” is a national demonstration model created in 1990 which provides a comprehensive family-centered program designed to meet the needs of substance abusing women and men, pre- and post-partum women and their children. Transportation is provided for all participants in this overall treatment recovery plan.

Contact: Dr. Johanna Ferman (202) 462-9129

“Fighting Back Initiative” of the Marshall Heights Community Development Organization.

Contact: Ms. Loretta Tate (202) 397-7300

“The Go-Getters Youth Club” Program of the Community Research, Inc.

The “Go-Getters Youth Club” provides recreational, social and cultural activities to youth of 9-21 years of age. Parents are involved in these activities through volunteering their services, as well as through staff-led workshops and counseling. As needs surface, staff also serve as supplemental parents to the youth.

Contact: Mr. Donald Freeman (202) 526-4039

“Marshall Heights Pre-Treatment and Abstinence Program” of the Marshall Heights Community Center

The Marshall Heights Pre-Treatment and Abstinence Program is a two-part program of stabilization (pre-treatment) and abstinence. Services are provided for all individuals and groups with day care provision and monthly family group sessions available.

Contact: Ms. Paulette Holloway (202) 397-7300

“MISAT Program”

MISAT, the Mentally Impaired Substance Abuse Treatment Program, serves the District by promoting substance abuse services as a part of case management. Day care services are provided so that participants may take part in one to one and group counseling.

Contact: Ms. Wella Johnson (202) 727-9002

“Progressive Life Center Substance Abuse Program” of the Progressive Life Center

The Progressive Life Center Substance Abuse Program operates from an African-centered approach to treatment, providing in-home family therapy and support services for parents. The sole referral mechanism for this program is the Youth Services Administration. Other family oriented components of the program include: parent training, family retreat weekends, monthly family healing groups and mother and sibling groups.

Contact: Ms. Pam Forester (202) 842-4040

“Project Support” of KOBA Associates, Inc.

Project Support deals with pregnant and post partum women addicted to crack. It is an outpatient program, providing transportation and child care for mothers and children. Mothers attend well-baby clinics, doctor appointments and

parenting classes. Families may participate until the child is two years old.

Contact: Ms. Ricke Glasgow (202) 526-9770

“Regional Addictions Program” (RAP) of the Regional Addictions Program, Inc.

RAP is a residential program for women and their children which promotes Afro-centrism, holds preparatory GED classes, and teaches life and parenting skills.

Contact: (202) 398-3390

“The Road to Success Program” of the Parklands Community Center

The Road to Success is a substance abuse prevention program which provides human and social support services to the parents of substance abuse children, among other activities. Weekly Parent Group meetings provide parents with child-rearing methods, health awareness, household budgeting strategies and substance abuse awareness.

Contact: Ms. Brenda Jones (202) 678-6500

“Substance Abuse Prevention Education” of the D.C. Public Schools

Substance Abuse Prevention Education works with the D.C. Public Schools in providing workshops to parents, teachers, students and the community on prevention and alternative activities to substance use.

Contact: Dr. Shelvie McCoy (202) 724-3610

Organizations and Contacts

Substance Abuse Prevention and Treatment: A Family Approach

This section contains an annotated list of organizations involved in substance abuse prevention and treatment that are of special interest to the District.

Center for Substance Abuse Prevention

Parklawn Building/Rockwall II
5600 Fishers Lane - Ninth Floor
Rockville, MD 20857
(301) 443-0365

Contact: Vivian L. Smith, Acting Director

The Center for Substance Abuse Prevention (CSAP) was created by the Anti-Drug Abuse Act of 1986 to lead federal efforts to prevent alcohol and other drug problems and to reduce the demand for illicit drugs. The Center is a component of the Substance Abuse and Mental Health Services Administration, Public Health Service. Activities and services include: funding demonstration projects targeting pregnant and postpartum women, their infants, and other high-risk populations; operating a national clearinghouse of publications and other materials and services; developing media campaigns and other knowledge transfer programs; and providing technical assistance for communities and organizations that develop and implement prevention and intervention efforts.

Center for Substance Abuse Treatment

Public Affairs Office
5600 Fishers Lane - Rockwall II Building
Rockville, MD 20857
(301) 443-5052

Contact: Lisa Sheckel, Acting Director

The Center for Substance Abuse Treatment (CSAT) is a component of the Substance Abuse and Mental Health Services Administration, Public Health Service. The Center works to improve and expand treatment and recovery programs for people who abuse alcohol and other drugs. It uses a comprehensive approach involving professionals and service providers in education, employment, housing, criminal justice and primary health care. Its programs target major U.S. cities, critical populations (adolescents, racial and ethnic minorities, residents of public housing, the homeless, rural and migrant populations), the criminal justice system and women, infants and children.

The Center for Mental Health, Inc.

3000 Connecticut Avenue, NW
Suites 106-108
Washington, DC 20008
(202) 462-2992

Contacts: Dr. Johanna Ferman, CEO and Medical Director

Vicki Ferrell, Director of Financial Development

The Center for Mental Health, Inc. (formerly the DC Institute for Mental Health) is a non-profit, community based organization, providing mental health and substance abuse treatment for the children and families of DC. Services at the Center for Mental Health, Inc. include adult/family and children services in substance abuse services, mental health services and primary health care and support services including parent/child re-unification services and life management skills training. Specific programs include the Family Health

Program, the Comprehensive Therapeutic Afterschool Program, professional and student training programs and the Early Identification/ Treatment/ Rehabilitation of Cocaine-Using Women and Children.

Center for Substance Abuse Research (CESAR)
4321 Hartwick Road, Suite 501
University of Maryland
College Park, Maryland 20740

The Center for Substance Abuse Research provides materials and reports on substance abuse specific to the DC area. Much of this information, including a monthly fax report of statistics and timely data, is free of charge to the public. CESAR also helps to conduct, with Koba Associates, Inc., the D.C. Drug Abuse Trends Analysis (DATA) Project which tracks the use and perceptions of various drugs by age group for D.C.

**Commission of Public Health
Alcohol and Drug Abuse Services
Administration** Office of Information, Prevention & Education 2146 24th Place NE
2nd Floor
Washington, DC 20018
(202) 535-2028
Contact: Patricia Jones

The Alcohol and Drug Abuse Services Administration (ADASA) is part of the Commission of Public Health, within the Department of Human Services of the District. ADASA provides assessment, counseling, treatment, outpatient, and inpatient services to persons seeking help with their alcohol and/or drug addiction. Services are provided to both volunteer and criminal justice clientele in treatment and prevention.

D.C. Commission on Social Services
609 H Street NE
Fifth Floor
Washington, DC 20002
(202) 727-5930
Contact: Pamela Johnson

The Commission works with community collaboratives of service providers, parents, and government representatives to articulate a continuum of services in support of children and families, to identify the services currently available, and to articulate and strategically plan the development of programs to fill special needs.

D.C. Community Prevention Partnership
1612 K Street, NW
Suite 1100
Washington, DC 20006
(202) 898-4700
Contact: Anita Hawkins

The goal of the D.C. Community Prevention Partnership, funded by the Center for Substance Abuse Prevention, is community empowerment. The Partnership supports community efforts to design and implement prevention initiatives through Ward Action Teams. In addition, the Partnership works with youth, who design their own Youth Action Teams to reduce substance abuse and violence in their neighborhoods. The Partnership also collaborates with other agencies in delivering the following services: family groups, programs for the elderly, leadership training, apprenticeship programs for young men, support services for parents, support for surrogate parents, programs for young women, school-to-work services, educational programs for young children, and support for young people in the criminal justice system.

Maat Center for Human and Organizational Enhancement
5113 Georgia Ave., NW
Washington, DC 20011
(202) 882-9744
Contact: Dr. Aminifu Harvey, Executive Director

The Maat Center for Human and Organizational Enhancement provides numerous services for the families of the District. Programs include parenting classes, education promotion, and prevention programs on substance abuse and violence.

Parents Association to Neutralize Drug and Alcohol Abuse

P.O. Box 314
Annandale, VA 22003
(703) 750-9285
Contact: Joyce Tobias, Newsletter editor

The Parents Association to Neutralize Drug and Alcohol Abuse (PANDAA) is a non-profit, parent group concerned about teenage alcohol and drug abuse. PANDAA tries to combat substance abuse in the home, school, and community by educating the public about all aspects of substance abuse. PANDAA maintains a confidential telephone service (703-750-9285) and works closely with the Fairfax County Public School System on prevention and educational projects. Membership is open to any individual and includes educational newsletters. Additional publications include "Kids & Drugs" and "Schools & Drugs", handbooks for parents, professionals, and educators.

Parklands Community Center

3230 Stanton Road SE
Washington, DC 20020
(202) 678-6500
Contact: Brenda Jones

The Parklands Community Center (PCC) is a non-profit, community based organization which serves the children, youth, and parents who live in the Shipley Terrace, Garfield, Congress Heights and Parklands neighborhoods of Ward 8. PCC provides direct human and social services, as well as forums for community residents and offers programs, such as the "Road to Success Program".

Substance Abuse and Mental Health Services Administration

5600 Fishers Lane, Room 13C-05
Rockville, MD 20857
(301) 443-8956
Contact: Elaine Johnson, Acting Director

The Substance Abuse and Mental Health Services Administration (SAMHSA), which succeeded

the Alcohol, Drug Abuse and Mental Health Administration in 1992, is the Public Health Service agency responsible for the prevention and treatment of addictive and mental health problems. It includes the Center for Mental Health Services (CMHS), the Center of Substance Abuse Prevention (CSAP), and the Center for Substance Abuse Treatment (CSAT). The agency helps state and local organizations to expand access to prevention and treatment programs, to increase the capacity and enhance the effectiveness of these programs, and to develop community-wide approaches to addictive and mental disorders.

Washington Area Council on Alcoholism and Drug Abuse (WACADA)

1707 L Street, NW
Suite 200
Washington, DC 20005
(202) 682-1700
Contact: Mr. Joseph Wright

The Washington Area Council on Alcoholism and Drug Abuse, Inc. (WACADA) is a nonprofit, community-based organization addressing the needs of persons addicted to alcohol and other drugs, as well as their loved ones. WACADA focuses on providing the public with information on substance abuse and its causes, and works to improve the care and treatment for substance abuse victims and their families. WACADA provides training and other prevention resources to community groups and campaigns for research on substance abuse and related health matters. WACADA operates a 24-hour hotline for people needing treatment or information.

Works Cited

- Brown, Sarah S. Ed. *Children and Parental Illicit Drug Use: Research, Clinical, and Policy Issues: Summary of a Workshop*. Washington, D.C.: National Academy Press, 1991.
- Center for Population Options. *Adolescent Substance Use and Sexual Risk-taking Behavior*, 1991.
- Committee on the Future of Alcohol and Other Drug Use Prevention of the Institute for Behavior and Health, Inc. *Stopping Alcohol and Other Drug Use Before it Starts: The Future of Prevention*. Rockville, Maryland, Office for Substance Abuse Prevention, 1989.
- D.C. Community Prevention Partnership. "DC Repeals Mandatory Minimums for Small-Time Drug Offenders." *Partnership Press*. January 1995.
- Friedman, Alfred S. "The Adolescent Drug Abuser and the Family." *Family Therapy for Adolescent Drug Abuse*. Friedman, Alfred S. and Samuel Granick Ed. Lexington, Massachusetts: Lexington Books, 1990.
- General Accounting Office. *Adolescent Drug Use Prevention: Common Features of Promising Community Programs*. Washington, D.C.: January 1992.
- . *Drug Use Among Youth: No Simple Answers to Guide Prevention*. Washington, D.C.: December 1993.
- Hawkins, J. David and Richard F. Catalano, Jr. and Associates. *Communities that Care: Action for Drug Abuse Prevention*. San Francisco, California, Jossey-Bass Publishers, 1992.
- Indices*. Washington, D.C., 1993.
- Institute for Health Policy, Brandeis University. *Substance Abuse: The Nation's Number One Health Problem: Key Indicators for Policy*. Princeton, New Jersey: The Robert Wood Johnson Foundation, 1993.
- Klitzner, Michael and Deborah Fisher, Kathryn Stewart, Stefanie Gilbert. *Substance Abuse: Early Intervention for Adolescents*. New Jersey: The Robert Wood Johnson Foundation, 1993.
- Mundell, Clare. *Drug Abuse in Washington, D.C.: Insights from Quantitative and Qualitative Research*. Center for Substance Abuse Research (CESAR) University of Maryland, College Park and Koba Associates, Inc. in cooperation with the D.C. Alcohol and Drug Abuse Services Administration, December 1994.
- National Association for Perinatal Addiction Research and Education. *Perinatal Addiction Research and Education Update: 1993 Legislative Update*. 1993.
- Office of Substance Abuse Prevention. *Identifying the Needs of Drug-Affected Children: Public Policy Issues*. Washington, D.C.: U.S. Department of Health and Human Services, 1992.
- Ooms, Theodora and Lisa Herendeen. *Adolescent Substance Abuse Treatment: Evolving Policy at Federal, State, and City Levels*. Washington, D.C.: Family Impact Seminar, 1990.
- . *Drugs, Mothers, Kids and Ways to Cope*. Washington, D.C.: Family Impact Seminar, 1990.
- Prothrow-Stith, Deborah and Michaele Weissman. *Deadly Consequences*. New York: Harper Perennial, 1991.
- Schippers, G.M. and Clemens Romijn, R. Hermans-van Wordragen. "Engaging Adolescent Drug Abusers and Their Families in Treatment: Dutch Versus American Results." *The Effectiveness of Drug Abuse Treatment: Dutch and American Perspectives*. Ed. Jerome J. Platt, Charles D. Kaplan, Patricia J. MC Kim. Malabar, Florida: Robert E. Krieger Publishing Company, 1990.

Schottenfeld, Richard S. and Richard R. Viscarello,
Judy Grossman, Lorraine V. Klerman, Steven F.
Nagler, Jean A. Adnopoz. "A Comprehensive
Public Health Approach." *When Drug Addicts
Have Children: Reorienting Child Welfare's Response*.
Ed. Douglas J. Besharov. Washington, D.C.: Child
Welfare League of America and the American
Enterprise Institute, 1994.

Sisson, Robert W. and Nathan H. Azrin.
"Community Reinforcement Training for
Families: A Method to Get Alcoholics into
Treatment." *Treating Alcohol Problems: Marital and
Family Interventions*. Ed. Timothy J. O'Farrell.
New York: The Guilford Press, 1993.

Snyder, Wendy and Theodora Ooms Ed.
*Empowering Families, Helping Adolescents: Family-
Centered Treatment of Adolescents With Alcohol,
Drug Abuse, and Mental Health Problems*.
Rockville, MD: U.S. Department of Health and
Human Services, 1992.

Squires, Sally. "A Profile of Area Drug Use."
Washington Post. November 8, 1994, 8-9.

Thomas, Edwin J. and Richard D. Ager. "Unilateral
Family Therapy with Spouses of Uncooperative
Alcohol Abusers." *Treating Alcohol Problems:
Marital and Family Interventions*. Ed. Timothy J.
O'Farrell. New York: The Guilford Press, 1993.

Thomas, Pierre. "Use of Drugs By Teenagers in
Increasing." *Washington Post*. December 13, 1994,
A1, A17.

U.S. Department of Health and Human Services.
*Turning Awareness Into Action: What Your
Community Can Do About Drug Use in America*.
Rockville, Maryland: Office for Substance Abuse
Prevention, 1991.