

In-home continuing care services for substance affected families: The Bridges Program.

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Abstract:

Addressing substance abuse in families is an important concern for the social work field. This article presents a preliminary view of a continuing care substance abuse recovery services program designed to assist the substance-affected family. The intervention approach is a blended model of substance abuse recovery work and family preservation. Services are directed at helping substance-abusing parents with “recovering” their role with their families, developing support for their recovery work, and helping them gain the education and skills they need for effective parenting, supportive family involvement, and avoidance of drugs and alcohol. The program focuses on helping substance abusers and their families achieve relapse prevention by addressing functioning in four domains: individual actions and cognitions, individual recovery actions, family actions and cognitions, and family recovery actions. The article presents two case examples to highlight the efficacy of the intervention model and the general positive effect continuing care services are having on substance-affected families.

Keywords: continuing care | families | family preservation | in-home services | substance abuse recovery | social work

Article:

The issues of substance abuse and its effect on the individual, family, and community remain a major challenge to the social work profession. When the substance abuser is a parent and has responsibilities for raising and supporting children, the challenge can be even greater. Not only must the issues of substance use and relapse prevention be addressed, but the demands of parenting and family must be considered as well. Many substance-affected parents are faced with hard choices in managing their recovery efforts and meeting their family responsibilities. Because of their addiction, they lack the ability to assume an effective parenting role or to be a supportive member of their family. Too often this results in a disengagement from the family, which has detrimental effects for the parent and the family. To help prevent this outcome, a

source of support to help with the transition back to parental responsibility and family involvement is needed. This support can be provided through continuing care substance abuse recovery services, which can help these individuals work on their recovery and develop the education and skills they need for effective parenting, supportive family involvement, and avoidance of drugs and alcohol.

The purpose of this article is to introduce a program model designed to address the recovery and family stabilization needs of substance-affected families. The model was developed from the strengths of proven family preservation, family support, and addiction recovery practices and addresses the issue of parent recovery from substance abuse and its influence on the effective functioning of the family system.

Involvement of the Family in the Recovery Process

It has been well established that the family plays a critical role in the recovery or relapse of the substance-dependent individual. Studies show that individuals are more likely to relapse when families fail to maintain involvement in treatment activities (educational, counseling, and self-help programs) than individuals from families who do stay involved (Daley & Marlatt, 1992; Daley & Raskin, 1991; Gorski & Miller, 1988; Hawkins & Catalano, 1985). When families participate in the recovery process, they are more likely to be supportive and less likely to "sabotage" the addict's recovery. They are also more likely to encourage the addict to seek support from a self-help network and to recognize factors that may interfere with recovery (Daley & Marlatt).

Involvement in the recovery activities is beneficial to the family in more than just providing support to the substance-affected family member. Other members of the family benefit when they have the opportunity to learn about addiction and its physical, psychological, and emotional effect. Family participation in the recovery plan helps them identify relapse warning signs, support efforts to remain abstinent, and achieve some control over the recovery process (Daley & Raskin, 1991). Participation in the process gives family members the opportunity to heal any emotional pain they may have experienced as a result of the addict's substance abuse history (Daley & Marlatt, 1992).

Effect of Substance Abuse on Children

In addition to the role that the family can play in helping the addict achieve recovery, it is vitally important to recognize the potential negative effect that substance abuse can have on children in the family. Research shows a strong link between parental substance abuse and child maltreatment (Child Welfare League of America, 1990; Famularo, Kinscherff, & Fenton, 1992; Sheridan, 1995). According to the Child Welfare League of America, substance abuse may be involved in as many as 80 percent of all substantiated cases of abuse and neglect. Substance abuse is one of the most common reasons children enter into the care of social services agencies (Children's Defense Fund, 1992). In a study conducted by the Child Welfare League of America

(1992), referral of over 40 percent of children to public and private child welfare agencies was related to substance abuse. The study also noted that substance abuse is a major factor in cases involving child protection, family disruption, and placement into foster care.

Psychological, cognitive-behavioral, and behavioral risks to children of substance-abusing parents are well-established (Aktan, Kumpfer, & Turner, 1996; Curtis & McCullough, 1993; Dore, Doris, & Wright, 1995; Julianna & Goodman, 1992; Sheridan, 1995). Dore, Doris, and Wright, in a review of how substance abuse affects children, reported that studies of psychosocial functioning have found that children from substance-abusing families are prone to behavior problems involving hyperactivity and conduct disorder, drug and alcohol use, impaired intellectual and academic functioning, clinical levels of anxiety and depression, low levels of self-esteem, and perceived lack of environmental control. Aktan, Kumpfer, and Turner reported that children in families of substance abusers are inclined to have ability deficits that impair their ability to solve problems, cope with stress, tolerate drugs, communicate effectively, consistently apply good standards, hold reasonable expectation, and be sufficiently interactive and supportive with others.

Effect of Substance Abuse on Parenting

In families in which parents abuse substances, parental control and protection factors are less evident and youths are more likely to exhibit behavior problems at home and school, be involved in delinquent activities, and use drugs and alcohol than youths from families in which parents do not abuse drugs (Julianna & Goodman, 1992). Drug-abusing families are likely to exhibit poor family management skills that lead to disruption, conflict, loss of parental control, low frustration tolerance, unrealistic expectations of children, weak child-parent bonds, low family cohesion, and undefined family boundaries (Julianna & Goodman; Sheridan, 1995). Also, there is evidence that when parents stop using drugs they become better parents (Murphy et al., 1991).

Assistance to Substance-Affected Families

Although the family is increasingly viewed as being important to the recovery process, less attention has been given to helping family members of recovering substance abusers (Aktan et al., 1996). Assistance to families has not been widely available in part because a strong focus on the substance-affected individual has dominated the field. Another, and perhaps more important reason, is simply insufficient attention to the assessment and treatment of families affected by substance abuse by professionals (such as social and child care workers) with responsibilities for serving children and families (Dore et al., 1995; Tracy & Farkas, 1994).

Tracy (1994) noted a reluctance on the part of social workers to address substance abuse problems adequately. Moreover, even when the social worker appropriately recognizes these family issues, the case management plan may be inadequate because of limited treatment sources and lack of preparation for addressing the effect of drug and alcohol use. Few programs have the comprehensive range of services to address the diverse needs of substance-affected parents,

which include special and developmental needs of children, child care and parenting skills, housing and vocational assistance, and counseling directed at the emotional consequences (for example, guilt and shame) of substance abuse.

The Child Welfare League of America's North American Commission on Chemical Dependency and Child Welfare (1992) has recommended that child welfare agencies recognize that parental alcohol and drug dependency places children at risk of abuse and neglect and provide services to undo the effects of abuse and neglect, stabilize the family, improve parenting skills, and prevent maltreatment. According to the Child Welfare League of America, "Chemically dependent families need intensive immediate and ongoing assistance to resolve AOD dependency, improve family functioning, and remedy the problems that chemical dependency creates for children" (p. 20). The report asserts that services must be provided to help parents improve their ability to perceive, understand, and respond appropriately to their children's needs. Also, it is important to consider the larger context of alcohol and drug use and how it might affect family needs such as housing, employment, medical care, sufficiency of social network, and contact and integration with the community.

Benefits of Family-Centered Home-Based Services

Azzi-Lessing and Olsen (1996) suggested that support is growing for service delivery systems to focus on the needs of families. They argued that a family-centered home-based approach would help women carry out their roles as parents and focus on the needs of their children and at the same time receive support and intervention services. Home-based services eliminate many of the obstacles (transportation or child care) that might limit family participation. Services delivered in the home also provide an opportunity to assess more fully the family's living situation as well as potential risks to children (Hodges & Blythe, 1992). This type of service delivery system also increases opportunities to provide a broad base of services (counseling, parent education, advocacy, concrete services) tailored to what the family needs and when the family needs it (Azzi-Lessing & Olsen).

Few programs provide home-based services to substance-affected individuals and their families. An exception is Project Connect, operated by the Rhode Island Center for Children-at-Risk, which provides therapeutic home-based and case management services that include substance abuse assessment and counseling, individual and family counseling, parent education, pediatric nursing services, and linkage with formal substance abuse treatment programs and other community resources. The program provides services for a six- to 12-month period. In a recent assessment of the project, the majority of a 66-case sample of mostly single-parent (single mothers) families with young children who received services made positive progress on their service goals (Olsen, 1995).

Preservation of the family is a primary goal of intervention with substance-affected families with dependent children in the home. In her evaluation of Project Connect, which provided some

home-based substance abuse treatment services, Olsen (1995) found that when parents were successfully involved in the services, 83 percent of those families' children remained in the home. By contrast, only 17 percent of children in families of unsuccessfully involved parents avoided out-of-home placement. Olsen concluded that

these data tell us that a project designed to offer supportive services to families struggling with problems of addiction can be successful in helping to maintain family ties and reducing the risk of child maltreatment in those cases where the parent is able to successfully engage in the recovery process. (p. 191)

Another project providing home-based services to substance-affected families has applied the Strengthening Families Program (Kumpfer & DeMarsh, 1985) in the Safe Haven program in Detroit (Aktan, 1995; Aktan et al., 1996). The goal of the program is to reduce risk factors for substance abuse when one of the parents is a known user. The program uses a 12-week family skills training approach to improve family communication, organization, expressiveness, and cohesion; increase parenting efficacy and parent-child bonding; and improve the child's school performance, positive behaviors, and association with positive peers. In-home family visits are conducted as part of the intervention.

Continuing-Care Substance Abuse Recovery Services

After a parent leaves a treatment facility, after-or continuing-care services are likely to be needed (Hawkins & Catalano, 1985). Olsen (1995) observed that parents with substance abuse problems are likely to need long-term support. Parents in recovery also are likely to be struggling with financial limitations, parenting skills, conflict with significant others, and finding positive supports in their lives. They are likely to need assistance in maintaining the progress they have made in treatment through transitional services such as safe housing and follow-up support for the family. Continuing-care services can address these needs and build self-efficacy to help parents assume responsibility for the changes they need to make. Failure to do so not only affects recovery for the abuser, but also has serious negative consequences for the family (Azzi-Lessing & Olsen, 1996).

Substance Abuse Recovery Process

Daley and Marlatt (1992) defined recovery as the process of initiating and maintaining abstinence from alcohol and other drugs as well as making intrapersonal and interpersonal changes. Recovering from a chemical dependency involves gaining information, increasing self-awareness, developing coping skills, and following a program of change. The goal of the recovery process is to have the recovering individual assume increasing levels of responsibility for dealing with problems and issues of a chemically free lifestyle.

DeJong (1994) asserted that most continuing care programs fail to completely help clients. He argued that this is because of a failure to develop coping skills that clients need to prevent

relapse in recovery. In general, past efforts have been refinements of primary treatment including posttreatment "booster" sessions, use of pharmacotherapies to reduce drug cravings, crisis intervention, unstructured continuing-care groups, and referral to self-help groups. Relapse prevention is likely to occur only if the client or addict takes actions to sustain recovery. These actions include maintenance of a sustained period of abstinence, acknowledgment of their chemical addiction, acceptance of abstinence as a goal, work on a long-term program of lifestyle change, and removal or reduction of personal and environmental factors that trigger their drug use.

Successful relapse prevention needs to include the development of skills to recognize situations and behaviors that elicit relapse behavior, to cope when confronted with situations associated with substance use, to control physiological and psychological cravings, to elicit positive support, and to avoid destructive and potentially harmful relationships. Recovering individuals need to achieve a positive mood state, develop a real understanding of how their behavior influences others, and adopt a value system that promotes a healthy lifestyle. To promote a healthy lifestyle, recovering individuals need to participate in activities that are incompatible with substance use, assume productive roles in the community, and participate in rewarding activities involving relaxation, healthy recreation, and emotion and stress management (Daley & Marlatt, 1992; DeJong, 1994).

In addition to the recovering adult, children in these families often need special attention. Intervention must include helping children understand and cope with the dynamics of substance abuse and providing opportunities to develop positive supportive relationships that can help them understand the effects of substance abuse and develop appropriate coping mechanisms (Julianna & Goodman, 1992).

Development of a Model Program

Practice approaches to the treatment of substance abuse are diverse. A study of 575 outpatient substance-abuse treatment managers, with and without social work backgrounds, found that ideologies of care were neither uniform nor static, and there was no consensus on preferred intervention approaches, even among managers with a social work background (Burke & Clapp, 1997). Views ranged widely, including support for abstinence-oriented as well as psychosocial and ecological approaches.

Along with the diversity of views on how to treat substance abuse problems most effectively, there are a number of suggestions for what an effective intervention model might include. In a study of successful completers of a family rehabilitation program, a sample of 20 recovering mothers achieved their success because of the program's ability to increase parental strengths, provide environmental support, and focus on educational and vocational achievement (Carten, 1996). Based on her study Carten suggested that an effective service delivery model should include an integration of intensive home-based services with community services. Tract (1994)

suggested that addressing the substance-affected family should include community-based outreach and case management approaches. Program services should be delivered in a consistent and continuous manner, should be intensive enough to motivate parents, and be directed at developing family and nonfamily support networks. A White Paper from the Office of National Drug Control Policy (1996) concluded that regardless of treatment setting or specific model, the critical elements of an effective intervention should include complete and ongoing assessment of the client, a range of services, a continuum of treatment intervention, case management and monitoring for appropriate intensity, and provision and integration of continuing social supports.

The Bridges Program

On the basis of recommendations from the literature and our own practice experience, we concluded that a family support or preservation approach to continuing care services for substance-affected families should capitalize on the strengths of the diverse field by embracing several areas of proven success. The model was developed from this perspective with an emphasis on building family support for recovery of the substance-affected parent.

The Bridges Program provides in-home continuing-care substance abuse recovery services to substance-affected parents and their families. The program was developed as a pilot project to address a gap in services. The program serves families in which at least one child is determined to be at risk of harm or out-of-home placement stemming from a parent's substance abuse. At least one parent must have recently been discharged from an intensive substance abuse treatment program. Families with a parent in recovery wishing to have an out-of-home child return home also qualify for program services. The program is based on an integrated model of relapse prevention and family preservation. Services address three basic primary goals (1) to help the substance abuser in maintaining the recovery process, (2) to help the family with the abuser's recovery, and (3) to provide family preservation or family reunification services.

Program Description

The Bridges Program helps the recovering client and his or her family develop skills and support activities to avoid relapse and develop a support network to facilitate the recovery process. Recovering parents are helped to reintegrate with their children and other family members, develop relationship and employment skills, and obtain community resources. The intervention curriculum focuses on chemical dependency--increasing self-awareness of and developing cognitive and behavioral skills to avoid the dependency. The program connects clients and their families with self-help groups (such as Alcoholics Anonymous, Narcotics Anonymous, or Al-Anon), teaches problem-solving skills, and helps obtain treatment and special assistance services. A strong emphasis is placed on meeting ecological needs of the client and family, which may include assistance in the areas of housing, transportation, child care, recreation, education, health care, and employment. Follow-up and crisis services are provided as needed for up to six months following termination of the primary service period.

Clients receive services over an eight-to-12-week period. Contact time includes four to six hours of direct services each week with the client and the family in their home and community. A substance abuse specialist, a master's level social work clinician with specialized training in substance abuse, provides the services.

To meet eligibility criteria for services, the family must be residents of the referring county, the referred parent must have recently been in either inpatient or intensive outpatient treatment, at least one child must be at risk because of parental substance abuse, and the family in the home must be willing to participate in a moderately intensive program. A multiagency case staffing team determines eligibility and appropriateness for services.

Intervention Domains

The program's intervention domains were selected to form a practice model that would support individual and family relapse prevention work. Selection of the components were guided by the relapse prevention model approach (Daley & Marlatt, 1992; Dale, & Raskin, 1991; DeJong, 1994) and by the addiction recovery approach (Gorski & Miller, 1988). The core domains were selected to achieve the service focus of linking parental recovery with family support. The domains and their respective components were included on the basis of their relationship to family and parent functioning and to their identified significance in contributing to relapse prevention.

The four domains are

1. individual actions and cognitions: behaviors and thinking patterns of the substance abuser that represent facets of functioning that are essential to engaging in a lifestyle not dependent on alcohol or drug use
2. individual recovery actions: behavioral changes that substance abusers must integrate into their daily lives to achieve and maintain sobriety
3. family actions and cognitions: behaviors and thinking patterns of the substance abuser's family that represent facets of family functioning that are essential to providing the support and structure the abuser needs to be able to engage in a lifestyle not dependent on alcohol or drug use
4. family recovery actions: actions that the families of substance abusers need to take to understand substance abuse and help the substance abuser achieve and maintain sobriety.

Achievement in each domain is measured through a series of assessment questions at case opening, case closure, and six weeks after closure of the case. Four levels of progress are depicted on a pictograph of the components of each domain (see Figure 1):

- Level 1 (innermost)--functioning at an unacceptable level, in urgent need of recognition of problems and actions to begin relapse prevention
- Level 2--functioning at a minimally acceptable level, needs to identify resources and begin to use them to address addiction-related problems
- Level 3--functioning at a moderately acceptable level, is inconsistent in practice of appropriate relapse prevention behaviors and uses support resources
- Level 4 (outermost)--functioning at an acceptable level, is consistent in engaging in appropriate relapse prevention behavior.

Components are scaled on a motivation to change or achievement of change dimension fashioned after the preparation stages of the change model of Prochaska and his colleagues (Prochaska, DiClemente, & Norcross, 1992). The domains and their components are used to develop and implement the treatment plan, which addresses family functioning and relapse prevention issues. Level of functioning within each domain is addressed so that the focus on the work with the family is to establish a strong link between family behavior and support actions and the substance-affected parent's functioning and recovery actions. The resulting picture that is created on the pictograph shows the individual and family movement toward recovery functioning and what specific domain components may need further work. (Examples of the intervention strategies derived from the model are presented in Gruber, Fleetwood, and Herring, 1998, which is available from the authors.)

Case Examples

Two case examples illustrate the intervention work of the Bridges Program and the application of the four-domain service model. The cases were selected to demonstrate the efficacy of the intervention model and the general positive effect continuing-care services is having on substance-affected families. Both cases were referred to the program by the local Department of Social Services.

Case 1. Reunification. The primary client was a white 38-year-old divorced mother of a 10-year-old son and a 15-year-old daughter. At the time the case was opened, the son was living in a foster home and the daughter was in a group home because the client was determined unable to parent her children adequately because of her substance abuse. She was receiving anger and grief counseling related to an accident that resulted in the death of her sister and her sister's son, for which she felt some responsibility. The accident was a major contributing factor to her drinking problem and the subsequent removal of her children. She also had been in an abusive relationship with her former husband.

The client lived with her mother, who blamed her for the loss of her daughter (the client's sister) and grandchild (the client's nephew). While in foster care, the client's son was sexually molested.

The client's mother exhibited strong anger toward her daughter and showed little willingness to support her recovery or reunification with her children. While the case was open, it was further complicated by the return home of a son of the client's late sister. He had been placed in an Eckerd Camp because of his oppositional behavior after the death of his mother. The return of the nephew served as a constant reminder of the deceased family members.

A continuing-care services plan was implemented to help the client establish a supportive home environment for herself and her children, support her efforts at grief and substance abuse recovery and maintaining sobriety, and assist in the reunification with her children. Support services included the development of a relapse prevention plan, addiction understanding counseling, emotional management and problem solving skills, and arrangements for attending weekly Alcoholics Anonymous meetings. The client's mother was offered support services, which included efforts to help her understand substance abuse addiction and how helpful it could be for her to be supportive of her daughter. The program also arranged for the client to receive dental care, vocational training, and funds to cover automobile repair and transportation costs for her children to visit her. The case was closed after the maximum 12-week service period.

At case closure the home environment had improved to the point that the client's son was allowed to return to live with his mother. Arrangements were made for the son and his mother to enter conjoint family therapy with a local psychologist to work toward repairing their relationship. The boy also began to receive counseling related to his sexual molestation experience. The client's daughter remained out of the home, but the likelihood of her returning had greatly improved because of her mother's progress with the program. The client's mother had made little progress toward understanding her daughter's addiction problems and the need for consistent family support. She did provide transportation (the client had lost her license to drive) and a place for her daughter and children to live. At the six-month follow-up period, the client was still alcohol and drug-free, gainfully employed, and her son was still living at home.

Services in this case were directed primarily at strengthening the mother's parenting skills and ability to provide for her children. Recovery goals were complicated because of deep feelings of grief and loss stemming from the death of a sister and nephew. Family support issues were critical because her mother was initially the primary emotional support source for the client. Important to the outcome of the case was for the client's mother to develop some appreciation of her role in helping her daughter work through the substance abuse issues and for her to support her daughter's efforts to reunite with her children. As the case progressed, the client established a wider support system through her employment and a support group at the local mental health center.

With respect to the four domains, the most progress was made in the individual recovery actions domain especially with social support, recovery work, and situation avoidance. Progress also occurred in the individual actions and cognitions domain, which included improvements in the client's emotion management, mood or affect, problem solving, motivation, and addiction

understanding. Positive movement in the family recovery actions domain was not strongly evident, but the mother's unintentional support of her daughter's alcohol problem was considerably lessened by the mother reducing her level of blaming her daughter for the accident, the molestation of the son while in foster care, and the fragmentation of the family. As a family, improvements in understanding addiction and problem solving related to substance abuse (family actions and cognitions domain) were minimal.

Case 2. Individual Recovery. The client was a 37-year-old white divorced father with a 15-year-old son. The boy was at risk of being removed from the home if the client was not able to control his use of alcohol and drugs. The client had recently been released from prison for multiple DWI convictions.

Case service activities included helping the client establish and follow a relapse recovery plan, attend and obtain a sponsor in Alcoholics Anonymous, and increase recreational involvement with his son. Work with the client led to increased support from his sisters, employer, and neighbors. The latter support provided some after-school supervision of the son while the client was still at work.

At the time of case closure, the son had a considerably better understanding of his father's substance abuse problem and actions necessary to help avoid relapse. The client's commitment to abstinence from alcohol and drugs was strengthened by his active involvement in his local Alcoholics Anonymous group. The client increased his recreational and contact time with his son through hunting and fishing trips, and the risk of the son being removed was greatly reduced.

Services in this case were directed primarily at the client's recovery actions. It was essential that he stop using drugs and recognize that continued use was going to cost him his son and his job. The client's recovery work led him to improve his relationship with his son, maintain his job, and become an ardent supporter of the substance abuse recovery community.

The client demonstrated an excellent understanding of the recovery process and the areas in which he needed to make life changes to avoid relapse. His greatest improvement occurred in the individual recovery actions domain areas of emotion management and problem solving, spiritual acceptance, recovery work, and situation avoidance. Improvement in the family recovery actions domain was evident by improvement in family support and some increased involvement in family support activities, but the latter remained in need of more attention. For this case, functioning in most areas of the family actions and cognitions domain were already good, with the exception of the family's ability to solve problems. At the end of the service period, this area was one of the strongest, demonstrated by the client and son's vastly improved relationship.

Limitations of the Study

The study has several limitations. First, the components of the model have not been independently validated as important or critical aspects of client-family recovery and

functioning. Second, the measurement of progress on the pictograph (from the inner to the outer layers) is based entirely on the subjectivity of the substance abuse specialist. Independent confirmation of client-family progress needs to be included in evaluation of the model's efficacy. Third, the conceptual framework for the model's components needs further development. As more families are served, it will be essential to relate relapse avoidance and family functioning to specific model components. It is also important that the application of specific components be standardized so that applications by the same and different child care professionals follow a common practice application core.

Conclusion

This article presents a preliminary view of a continuing-care program designed to assist the substance-affected family. The intervention approach is a blended model of substance abuse recovery work and family preservation. Services are directed toward helping substance-abusing parents "recover" their role with their families and develop support for their own recovery work. The domains identified for emphasis in the model represent well-established components of recovery and relapse prevention. Appreciably, more work is needed to identify the most critical areas of the domains and how best to help recovering individuals master the information and skills represented in the domains. One of the greatest challenges is to involve family members more fully in the recovery process, particularly in cases in which the family relationships are strained or broken. Family support can be critical not only for the abuser's recovery, but also for the healthy development of children and positive role development.

The goal of the Bridges Program is to help "bridge" the transition that substance-affected parents must make when they extend the recovery process to their roles as provider, supporter, and nurturing adult in their families. Support for this bridge must come from the family and the community. As a pilot program, Bridges is striving to develop the essential community links that will tie child and family services to the substance abuse recovery network. The Bridges Program hopes others will consider the potential effectiveness of continuing-care programs in their communities. We believe that extending support beyond the "program walls" into clients' homes and their families will ensure that more substance-affected parents will be involved with their children's development and provide a safe, stable, and healthy environment for their children to thrive.

We hope that the social work profession continues to develop more creative approaches to address the immediate and long-term needs of the substance-affected family. More attention should be directed at the multigenerational effects of family substance abuse and to research that establishes effective ways of helping families achieve recovery.

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