
CRACK BABIES: SELECTED MODEL PRACTICES



OFFICE OF INSPECTOR GENERAL
OFFICE OF EVALUATION AND INSPECTIONS

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This report describes selected model practices which may be effective in assisting drug-exposed babies and their families. These models were encountered during an inspection examining how crack babies affect the child welfare system. The findings from the Crack Babies inspection are contained in a separate report, OEI-03-89-01540.

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CRACK BABIES: SELECTED MODEL PRACTICES

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INTRODUCTION

PURPOSE

This report describes selected model practices which may be effective in assisting drug-exposed babies and their families.

These models were encountered during an inspection examining how crack babies affect the child welfare system. The findings from the Crack Babies inspection are contained in a separate report.

BACKGROUND

During the Crack Babies inspection, we found that public and private agencies are struggling to cope with the increased volume of drug-exposed infants and the multiple service needs of their families. Services are provided to families considered to be at "high-risk." Some indicators of high-risk family circumstances are poverty, substance abuse, family disruption, and abuse or neglect.

Agencies identified many service problems. Some agencies have problems providing early intervention services, comprehensive case management, and caseworker training. Study respondents are also concerned about the special educational needs of these children and the lack of interagency coordination.

In this report, we describe practices being used by public and private agencies, and State and local governments to address some of these problems.

The Crack Babies inspection found that the problems caused by crack are inseparable from the larger issue of prenatal exposure to other drugs including alcohol. Accordingly, programs and procedures described in this report are not limited to those dealing with crack or cocaine exposure.

METHODOLOGY

We collected information in 12 metropolitan areas during the last quarter of 1989. Respondents included child welfare administrators and caseworkers, hospital social services staff, private agency representatives, foster parents, State and local officials, and national experts. These respondents identified programs and procedures which they considered effective in assisting drug-exposed babies and their families. While all programs cited in this report were contacted and most were visited, we did not attempt to assess their effectiveness.

CATEGORIES OF MODEL PRACTICES

This report is a selection of model practices which may be effective in assisting drug-exposed babies and their families.

Practices are presented in eight categories:

- I. COMMUNITY OUTREACH AND EARLY INTERVENTION**
- II. COMPREHENSIVE SERVICES IN ONE LOCATION**
- III. EDUCATION FOR DRUG-EXPOSED CHILDREN**
- IV. CASE MANAGEMENT**
- V. PROFESSIONAL TRAINING**
- VI. MANAGEMENT PRACTICES**
- VII. INTERAGENCY COORDINATION**
- VIII. PRIVATE INITIATIVES**

More information on these practices can be obtained from contacts listed in the appendix.

I. COMMUNITY OUTREACH AND EARLY INTERVENTION

Community outreach involves going into neighborhoods to find drug abusing women and their children. The next step is to encourage them to use available medical and social services. Aggressive outreach gets women and children to services they would not otherwise receive. Early intervention means identifying problems in their early stages and providing appropriate services in order to prevent serious problems.

The following four programs provide outreach and/or early intervention to families in their communities.

The Maternity Outreach Mobile (MOM) Project is administered by the Department of Human Services (DHS), Commission on Public Health, Office of Maternal and Child Health, in the District of Columbia. The MOM Project conducts early identification and treatment of high-risk populations through screening, referral, and follow-up. The project is a response to the high infant mortality rates in the District.

The MOM targets pregnant women, parenting women, and infants in high-risk areas. The van canvasses neighborhoods, parks, and shopping areas looking for mothers and infants. It also takes referrals from DHS and a variety of other sources.

Outreach workers in the van try to enroll high-risk women and infants into the MOM project. The workers then refer women for care to the nearest health center or health care provider. The MOM van staff also take women to appointments and follow-up to be sure women are using the services.

St. Lukes/Roosevelt Hospital Center, New York City, has two programs within its Community Services for Children and Families: the Prevention Unit and the First Step Unit. Since the units are affiliated with the hospital, their clients have access to the wide range of services offered by the hospital.

The New York City Child Welfare Administration (CWA) contracts with both units and provides a large portion of their funding. The First Step Unit also receives 25 percent of its budget from private sources and foundations.

The Prevention Unit serves multi-problem families, most of whom are referred by CWA. At least 6 of their 42 families must be "boarder baby" prevention referrals. The unit is staffed by social workers, psychologists, and volunteer home visitors.

The Prevention Unit seeks to prevent foster care placement, decrease the incidence of child abuse and neglect, improve the parents' ability to deal with psycho-social crises, and promote the personal development of parents and children. The staff assumes case management and clinical responsibility for the family with personalized coordination strategies. The coordinated services include counseling, crisis intervention, home visits, and parent-child interaction therapy.

The First Step Unit serves 24 pregnant teenagers and teenage mothers with infants. Staffed by social workers and volunteer home visitors, the unit seeks to improve parenting skills, reduce psycho-social stress, foster personal development, increase self-esteem, and reduce potential foster care placement. The home visitors help increase the mother's knowledge of the physical and emotional needs of her baby. The staff supports the mother in dealing with conflict and stress, and motivate her to consider the choices for her future.

The Harbor/UCLA Medical Center in Torrance, California has a Substance Abusing Mothers (SAM) Clinic. The SAM Clinic provides support and care to pregnant women addicted to illicit drugs. Eighty percent of the infants born to women attending the clinic have been drug-free at birth. The infants have a reduced incidence of prematurity and low-birth weight, shorter neonatal stays, fewer perinatal deaths, and a decreased need for foster care as compared to other babies born to addicted women not in this program.

Staff include a clinic coordinator, perinatologist, developmental psychologist, psychiatrist, dietician, and nurse educator, as well as pediatricians, OB-GYN housestaff, and certified nurse midwives. The services provided are prenatal care, pediatric care, social service case management, chemical dependency treatment, parent education, support groups, individual and group counseling, community outreach, and family planning. The funding for these services comes from the county Drug Abuse Program and State funds set aside for hospitals in targeted counties.

There is also a clinic for children of substance-abusing mothers that does developmental testing and assessment. Babies are followed at 4-month intervals during their first year and 6-month intervals thereafter.

The Center for Family Life in Brooklyn, New York is a multi-service agency serving the Sunset Park community of Brooklyn, a poor neighborhood of some 98,000 people.

While its primary focus is to sustain children in their own homes through a variety of supportive services, it recently developed a pilot foster family program in which foster families are matched with natural families within the same neighborhood when placement is necessary. Supported by a contract with the New York Child Welfare Administration, the program's purpose is to reduce the trauma of separation for children who have to be removed, to keep siblings together, and to offer more intensive services aimed toward family reunification. After children are returned to their parents, the family is encouraged to remain connected with the Center for ongoing support and risk reduction. The Center has found neighborhood foster family homes for 64 children and has returned 33 to their parents.

The Center's family services include individual, group, and family counseling; psychological and psychiatric assessments; an infant/toddler/parent program; foster grandparents; employment services and job placement; emergency food; an advocacy clinic; and extensive school-based activities. The latter include school-age child care services at two schools, as well as two teen centers and summer day camp programs.

The Center for Family Life has developed services that directly meet the needs of its neighborhood clients. It is involved in developing the community as well as with individual and family clients. This commitment is reflected in the Center's policy of being available to the neighborhood 7 days and evenings a week.

II. COMPREHENSIVE SERVICES IN ONE LOCATION

Central locations offering comprehensive services are a preferred approach for reaching and serving drug-addicted women and their families. Service needs include medical care, counseling, and social services. The facilities provide services directed at the multi-dimensional needs of drug-affected families. The availability of a variety of services at one location makes it easy and convenient for families to accept services.

Descriptions of three facilities which provide comprehensive services to drug-addicted women and their children follow.

Martin Luther King Jr. Hospital in Los Angeles, California is a county facility where four programs are available for drug-exposed babies and their families. These programs are part of an umbrella program called Shield for Families.

The first program, Project Support, provides prenatal care and outpatient drug treatment to clients referred primarily by the hospital. The California Department of Children's Services (DCS) can mandate individual participation in the program by means of a court order. The county Drug Abuse Program provides funding.

The second program, High-Risk Infant Follow-up, is a clinic that provides medical care for infants and ensures they receive necessary services. It is for children from 0 to 5 years of age who have developmental needs or are at high-risk. Children are referred from other Shield for Families' programs as well as by DCS, hospitals, and other foster care agencies. The program is funded by the county Department of Health Services.

The third program is Assistance and Relief to Kids (ARK), a child abuse project for high-risk women funded by the State. Upon recommendation from DCS, the courts can order mothers to attend the program. The ARK program receives its funding from a State-administered Federal grant for model programs dealing with child abuse.

The fourth program, Eden Infant, Child and Family Development Center, consists of early developmental assistance for drug-exposed newborns and their families with special needs. The program's funding comes from the United Way, DCS, and the county Drug Abuse Program. Eden offers center and home-based programs focusing on parental skill development. Mothers participate in both for a total of 1 year.

The center-based program includes parenting classes, counseling, psychological evaluations, and Cocaine Anonymous meetings. Eden's home-based program includes further counseling, implementation of new parenting skills, and application of new management skills. It also includes family assessment with an individualized treatment plan developed with family input.

Family Health Center in Miami, Florida is a treatment community for female substance abusers which allows mothers to keep their children with them while attending the program. The Center offers comprehensive primary care and addiction services which include outpatient services, day treatment, and residential components. Currently there are 15 residential beds, with 25 more being planned.

The Center receives funding from the U.S. Department of Health and Human Services and the Florida Department of Health and Rehabilitative Services. The residential program lasts 6 to 9 months, is self-paced and employs a token system. The token system allows patients to earn points needed to move through treatment phases.

The residential program's goal is cognitive growth. In addition to drug treatment, enrollees receive vocational training, tutoring for high school equivalency diploma, parenting and nutrition classes, psychological counseling, AIDS prevention training, transitional housing, child care, and health care. Women attend physical fitness and art classes, along with community social events and Narcotics and Alcoholics Anonymous meetings.

To graduate, a woman must be employed for 90 days, have \$500 saved, possess facility-approved housing, and have or be working toward her high school diploma. After graduation, participation is required in an outpatient program which includes random drug testing. Center staff conduct follow-up if the women do not attend.

The Women's Annex in Tacoma, Washington provides transitional housing for women (and their children) recovering from drug and alcohol abuse. To live in the Annex, women must have attended or be attending drug treatment and be in school or working. The Annex consists of seven houses with a resident manager and case manager on-site at all times. The staff assist women in securing services and resources they need to stay drug-free.

The houses are designed to offer a supportive home environment for women and their children. Services include child care, transportation, recreation, and workshops. Women also have access to employment and education resource and referral information. The women may stay as long as necessary to maintain drug-free sobriety and work towards independence. More information on Women's Annex is provided in Section VIII, Private Initiatives.

III. EDUCATION FOR DRUG-EXPOSED CHILDREN

Serious concerns exist about the future impact of drug-exposed babies on school systems. Drug-exposed babies are considered likely to have developmental, behavioral, psycho-social and learning problems which school systems and preschool programs will face. With early intervention, many professionals believe these children can be mainstreamed. Both programs described below provide a structured educational program for preschool children.

The Los Angeles Unified School District has a pilot research program for drug-exposed children which uses special local and State education funds. Since its inception in 1987, 31 children between the ages of 3 and 6 have participated.

The program targets marginal children, i.e., those who may ultimately be integrated into regular classrooms. Children are referred to the program by the Department of Children's Services, foster parents, and relatives. Upon referral, the staff perform an initial child assessment to determine if the program is appropriate. The program's initial goals are to develop strategies for teaching regular teachers about the unique needs of drug-exposed children, and determine if there are similar characteristics among drug-exposed children. As stated in the program manual, "There is no typical profile of a drug-exposed child, and as such, each child must be educated as an individual with particular strengths and vulnerabilities."

Three other program aims are:

- to identify preschool children at risk for behavioral and developmental learning problems due to prenatal drug and/or alcohol exposure;
- to develop effective strategies and provide structured learning experiences to promote cognitive, communicative, psycho-social and motor development of children prenatally exposed; and
- to facilitate the successful transition of prenatally exposed children to a regular education setting or to the least restrictive special education program.

The program provides morning classes that last 3 hours and 20 minutes for preschool-age children and full-day classes for children 5 years and older. The staff include a social worker, psychologist, doctor, and three teachers. Each teacher handles 6 to 8 children, providing consistency and reliability through daily routines. This approach strengthens a child's self-control and builds a sense of mastery over the environment.

The child's home life is also considered an essential part of the curriculum; home visits and parent education classes are conducted. When needed, the family is offered mental health services. Parental confidence and competency are increased through intervention strategies which strengthen the positive interaction between child and family.

Head Start is a child development program for preschool children from low-income families. It is funded by the U.S. Department of Health and Human Services, Office of Human Development Services. Projects are administered at the local level.

In recent years, Head Start programs around the country report they are serving increasing numbers of dysfunctional families, many with drug abuse problems. Head Start families may have special needs and experience difficulty coping with aspects of daily living. A number of Head Start programs have created unique local partnerships with mental health centers and child welfare agencies to address these problems. A survey of problems and model programs is contained in the November 1989 OIG report, "*Dysfunctional Families in the Head Start Program: Meeting the Challenge*," (OAI-09-89-01000).

IV. CASE MANAGEMENT

Quality case management can help ensure that drug-addicted mothers and their children receive essential services. Case management means guiding families to services including health care, counseling, physical therapy, drug rehabilitation, parenting classes, and vocational training.

Two programs which provide both case management and direct services to drug-addicted mothers and their babies are described below.

The *Center for the Vulnerable Child (CVC)* in Oakland, California provides case management to high-risk children. Two CVC goals are to "meet the health care, developmental and social needs of vulnerable children" and to "coordinate services to provide comprehensive care." The CVC services are funded primarily through money from private foundations.

The Chemical Addiction Recovery Efforts (CARE) Clinic is one CVC program. The clinic serves chemically dependent women and their drug-exposed infants. A pediatrician, nurse, and therapist/case manager with special chemical dependency expertise staff the clinic.

The CARE Clinic provides both medical and counseling services. Medical services include pediatric care, developmental assessment, and parent training. Staff specialists visit homes to teach families about the recovery process and their infant's development. Mothers also gain support through individual counseling, group meetings, and family therapy.

The case manager's role adjusts to client needs. The case manager may serve "as problem solver, role model, advocate, broker, assessor, planner, service monitor, record keeper, therapist, collaborator, and detective." Further, the case manager consults with specialists and community providers to offer mother and child a variety of services.

The *Perinatal Outreach Project* in Washington, D.C. provides in-home skilled nursing, social services, and professional therapeutic services to prenatal and postpartum patients and at-risk newborns. The Project served approximately 800 clients in 1989. An estimated 80 percent of the babies served were from drug-affected families. The project is managed by Children's Home Health Care Services with funding from the D.C. Commission of Public Health, Office of Maternal and Child Health. Clients are referred by local hospitals and the Department of Human Services.

Outreach staff track mother and child to ensure they are getting adequate medical care. The Project also helps prevent duplication and fragmentation of services to this high-risk population. Staff nurses conduct an average of three to five in-home visits per month. During these visits, they teach women about prenatal and postpartum care and child rearing.

The staff counsel individuals about educational, financial, social service, and employment needs, and assist families in accessing medical and food supplement programs. They also identify programs and make appropriate referrals based on individual family needs.

V. PROFESSIONAL TRAINING

Professionals who work with drug-addicted women and drug-exposed children have specific training needs. The training components cited below include recognizing substance abuse and identifying the medical and social services needs of drug-exposed babies and their families.

The *National Association for Perinatal Addiction Research and Education (NAPARE)* has developed and disseminated training curricula for social service and health care professionals. They have offered to share this curricula with child welfare agencies and physicians' associations. Recognizing that professionals often take inadequate substance-abuse histories, NAPARE emphasizes the need to take comprehensive substance-abuse and lifestyle histories. The curricula includes guidelines for recognizing, assessing, and treating substance-abuse cases. It is designed for physicians, social service and drug and alcohol caseworkers, and family court judges and attorneys.

The University of California at Los Angeles developed *Project TEAMS (Training, Education and Management Skills)* to train workers to deal with the special needs of drug-exposed babies placed with foster parents and relative caregivers. The TEAMS "curriculum supports a service delivery model which is interdisciplinary in practice, interagency in focus, and holistic in its approach towards infant, family, and caregiver needs."

Project TEAMS was funded by the National Center on Child Abuse and Neglect from April 1986 through May 1988. The project has since been expanded to include biological parents and is supported by the Los Angeles County Board of Supervisors and the Department of Children's Services. Project TEAMS also has a contract with the county to train physicians about issues concerning drug-exposed babies.

Currently, the U.S. Department of Education's Handicapped Children's Early Education Program is funding an expansion of the program to provide training and technical assistance to public and private agencies working with chemically dependent families in communities throughout California. The program creates skilled interdisciplinary teams of child protective services workers and public health nurses. These teams, in turn, help caregivers create healthy, nurturing environments for their drug-exposed infants.

Training for the child protective workers and public health nurses lasts 6 months. The first phase of instruction concerns the effects of substance-abuse on the developing fetus, infant, child, parents, and entire family. This phase also involves establishing guidelines for assessment, intervention, and interagency collaboration.

The second phase is a clinical component consisting of case management, individual consultations, and monthly small-group consultations. Teams conduct home visits with infants and caregivers. The trainees also attend group meetings to discuss issues relating to these babies and their foster parents.

VI. MANAGEMENT PRACTICES

Several States and local governments have established management practices to improve tracking and supervision of child welfare cases involving drug exposure. These practices include automated central registries, special drug baby units, and fast tracking of the legal process. Although several States and cities have these practices, only one example of each is cited.

Many States have central registries where child abuse and neglect cases are reported. In Florida, these cases are referred to the Department of Health and Rehabilitative Services (HRS). The *Florida Abuse Registry* was established by Departmental directive in October 1988 to provide a single statewide 800 toll-free number for reporting all suspected child abuse and neglect cases. The HRS regulations require centralized reporting of all newborns "who are born to mothers who are addicted or have abused drugs during the childbearing period." The Department also requires that drug-affected families and substance-abusing pregnant women "be given the highest priority in service provision."

The *Department of Children's Services (DCS)* in Los Angeles has established two *high-risk drug baby units*. The units perform three functions: emergency response, custody investigations, and family maintenance. They operate on a vertical case model, where each caseworker performs all three functions in order to ensure consistency in case management.

When an infant is first referred, DCS intake evaluators use a special high-risk intake form. When information obtained meets selected criteria, the baby is referred to the high-risk unit for assessment.

In the unit, social workers use a special risk assessment guide for infants prenatally exposed to drugs. The guide, along with personal interviews, aids in determining the infant's placement. If the infant cannot be safely released to the mother, a custody petition is filed in court. If the child is allowed to go home with the mother, a family maintenance plan is developed.

A legal process known as "*fast tracking*" has been implemented in Dade County, Florida. The process helps expedite the less complex dependency cases through the court system by prescribing specific time slots for child welfare cases. This results in quicker placement decisions. Fast tracking is a coordinated effort among Florida's Department of Health and Rehabilitative Services, the Juvenile Justice System, and the State Attorney General's Office.

VII. INTERAGENCY COORDINATION

Interagency coordination is necessary to ensure that services to families are available, accessible, and not duplicated. Lack of coordination among service providers is a major problem case managers face in offering multiple services to drug-affected families. The following two programs are using interagency coordination to address the issues and consequences of drug use in their communities.

The *Illinois Model* is an innovative interagency coordinated effort to address the needs of cocaine and other drug-exposed infants. The agencies participating in and funding the project are the Illinois Department of Children and Family Services, the Illinois Department of Alcoholism and Substance Abuse, and the National Association for Perinatal Addiction Research and Education (NAPARE). The three agencies use an education, prevention, referral, and coordinated intervention strategy.

The Illinois Model has "reduced systems barriers to integrated services and made available a full complement of services to high-risk families." The Model has provided integrated medical, substance-abuse, and social services to over 400 mothers and infants since 1986.

One of the model's components is a confidential, toll-free "Cocaine Baby" Helpline. The helpline provides information and referral to individuals in five midwestern states. The toll-free number is staffed by a pediatrician and a pediatric nurse practitioner who refer women to clinics and physicians for medical care and drug treatment.

The agencies have co-sponsored three national training conferences and developed a national newsletter to provide an educational forum about cocaine use and pregnancy. The NAPARE has also developed curricula to train medical, social service, and substance-abuse professionals to recognize, refer, and treat cocaine-affected infants.

The *Governor's Commission for a Drug Free Indiana* was established by executive order in May 1989 to examine Indiana's overall drug problem with special emphasis on local issues such as crack abuse. Commission members have diverse backgrounds in youth services, law enforcement, business, education, child welfare and protection services, medicine, drug and alcohol abuse and treatment, and other social services.

The commission serves as an umbrella organization to support local coordination and initiatives in the war against drugs. It tracks local funds, informs the Governor of local needs, and advises localities of State legislative initiatives.

Funding is drawn from a variety of Federal and State programs including the Alcohol, Drug Abuse, and Mental Health block grant, Criminal Justice block grant, National Highway Safety funds, and Indiana's Drug Free Communities grant program.

VIII. PRIVATE INITIATIVES

Several programs visited during the Crack Babies inspection were initiated with private funds. These programs were private sector responses to current social problems. Two of the three programs described now receive some public funding.

The Women's Annex (previously described) was funded by a local attorney who acquired seven houses and renovated them into housing for women recovering from drug addiction. Several of the houses were formerly crack houses. The services are funded through private contributions and the Washington State Division of Alcohol and Substance Abuse.

The Children's Home Society of Miami, Florida offers a variety of services for infants and children to age 18. They provide pregnancy counseling, adoption services, residential foster care, foster homes for children with AIDS, emergency shelters for infants and children, social services for developmentally delayed children, and group homes for teens. Their services are now under contract with the Florida Department of Health and Rehabilitative Services.

In 1986, Burger King, with help from other local businesses, built the facility containing their administrative offices and an emergency shelter. Funds to construct the infant center were donated by a local foundation. A significant portion of the Society's operational costs are paid for with United Way funds and private contributions.

The California Medical Center in Los Angeles runs a program called Rebirth for substance-abusing mothers and their infants. The program provides education on maternal drug abuse to mothers in hospitals. Rebirth also trains caregivers on the special needs of the drug-withdrawing infant. A nurse conducts follow-up home visits to check the infant and answer any questions. The program, which receives no public money, is funded by the California Community Foundation and private donations.

APPENDIX

CONTACTS:

I. COMMUNITY OUTREACH AND EARLY INTERVENTION

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