

Family-Centered Treatment for Women With Substance Use Disorders: History, Key Elements and Challenges



Family-Centered Treatment for Women With Substance Use Disorders - History, Key Elements, and Challenges

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JBS International, Inc., and

The Center for Children and Family Futures, Inc.

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About This Series

As part of its commitment to ensure that people have access to effective treatment and supportive services that promote their recovery, the Substance Abuse and Mental Health Services Administration (SAMHSA), Center for Substance Abuse Treatment (CSAT) has prepared two papers on family-centered treatment for women with substance use disorders. *Family-Centered Treatment for Women with Substance Use Disorders – History, Key Elements and Challenges* introduces, defines, and discusses the concepts and implementation challenges of an evolving family-centered treatment approach for women with substance use disorders. The companion paper, *Funding Family-Centered Treatment for Women with Substance Use Disorders*, identifies and discusses potential sources of funding for comprehensive family-centered treatment, and provides suggestions for how States and substance abuse treatment providers can strengthen their overall financing strategies.

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EXECUTIVE SUMMARY

Edith Schaeffer (2001) provides an analogy between a family and a mobile. Each member, an individual art form, is connected to the others through invisible strings. When the wind blows, all parts move individually and harmoniously. Mobiles are delicate. If one piece breaks, if a string is severed or becomes knotted, the whole mobile is affected. Similarly, the actions of one family member affect the entire family. Families tie together households, as economic units, as well as providing child-rearing, human interactions, and cultural traditions.

This briefing paper looks at the role of family in the context of treatment for women with substance use disorders. First a continuum of family-based services is presented. This continuum offers a framework for defining and discussing different ways of approaching family involvement in treatment services. The remainder of the paper explores a comprehensive model of family-centered treatment including key principles, components, modalities of delivery, and challenges to establishing and operating family-centered treatment programs. This paper is informed through an extensive literature search and review, as well as information gathered from experts in family-based services. Expert knowledge was garnered from participants in a symposium titled A Practice-Based Symposium on Comprehensive Family-Centered Treatment held in July 2005 by the Substance Abuse and Mental Health Services Administration (SAMHSA), Center for Substance Abuse Treatment (CSAT), in conjunction with the Rebecca Project for Human Rights. (See Attachment 2 for a roster of participants.)

There are two primary reasons why family-centered treatment for parental substance use disorders makes sense. First, research on women's substance use, dependence, and treatment shows that relationships, especially with family and children, play an important role in women's substance use, treatment, and relapse. Second, 70 percent of women entering treatment have children. These children are at high risk of child abuse and neglect, developmental problems, and adolescent substance use.

Therapeutic services and improved parenting improve the prognosis and outcomes for these mothers and their children. When whole families are treated, outcomes for each individual member improve while simultaneously the communication, coordination, and ability of adult members to support one another and the children increase.

Continuum of Family-Based Services (abbreviated)	
LEVEL 1 Women's Treatment With Family Involvement	Services for women with substance use disorders. Treatment plan includes family issues, family involvement. Goal: improved outcomes for women.
LEVEL 2 Women's Treatment With Children Present	Children accompany women to treatment. Children participate in child care but receive no therapeutic services. Only women have treatment plans. Goal: improved outcomes for women.
LEVEL 3 Women's and Children's Services	Children accompany women to treatment. Women and attending children have treatment plans and receive appropriate services. Goals: improved outcomes for women and children, better parenting.
LEVEL 4 Family Services	Children accompany women to treatment; women and children have treatment plans. Some services are provided to other family members. Goals: improved outcomes for women and children, better parenting.
LEVEL 5 Family-Centered Treatment	Each family member has a treatment plan and receives individual and family services. Goals: improved outcomes for women, children, and other family members; better parenting and family functioning.

This paper presents a Continuum of Family-Based Services with five progressively more intensive levels of family-based services. Although expert panelists at the symposium acknowledged the importance of defining terminology, they also noted that the terms used to describe services vary. Terminology must remain flexible because meanings vary across collaborative agencies and because funding streams often use strictly defined categories and terminology. Programs fall along this continuum, depending on who is targeted and the services they receive; suggested outcomes accompany each level. At a minimum, family-based services acknowledge the influence and importance of family, provide for family involvement, and address family issues in individual treatment plans. The most comprehensive model of family-based services is the family-centered treatment model.

For women, ego development is organized around making and maintaining affiliations and relationships. Troubled family systems and disrupted living patterns accompany substance use. These troubled systems must establish harmony for women who use substances and their families to recover and develop or return to healthy family functioning. Family-centered treatment may mitigate both individual and family risk factors and build protective factors, reducing the incidence of relapse in adults and substance use in children. Family-centered treatment offers a solution to an intergenerational cycle of substance use and related consequences by helping families reduce substance use and improve child health and safety.

Attachment 3 contains CSAT's Comprehensive Substance Abuse Treatment Model for Women and Their Children (Comprehensive Model) as revised by the CSAT Women, Youth and Families Coordinating Committee. Family-centered treatment expands the Comprehensive Model to include older children, fathers, husbands, partners, and other family members. The Comprehensive Model recognizes three primary types of services for women with substance use disorders and their children: clinical treatment, clinical support, and community support, provided in a context of cultural competence, gender competence, and developmental appropriateness. In family-centered treatment the Comprehensive Model is expanded to include individualized screening, assessment, and case planning for each member of the family. In addition to offering services to individual family members, family-centered treatment offers services to the whole family that build on all members' strengths to improve family management and functioning.

Collaboration is an important element of family-centered treatment. Client families are often involved in multiple systems (e.g., child welfare, criminal justice, social services). Likewise, these and other service systems have resources to address some of the complex needs of these families (e.g., parenting support, child development, mental health). Family-centered treatment strives for outcomes that involve multiple service delivery systems.

Programmatic challenges include questions about whom to involve, when to involve them, and how children affect the treatment dynamic. Central to programmatic challenges is the need to provide a safe, constructive, drug-free environment for all clients and family members and the need to maintain individualized services and flexibility to accommodate the array of family needs. Significant administrative challenges are inherent in the family-treatment model. Agencies that provide this model tend to be more complex in their policies and procedures, staffing patterns, facilities, evaluation, and funding sources. The companion to this paper, *Funding Family-Centered Treatment for Women with Substance Use Disorders*, provides a

review of available funding streams that fund family treatment or components of family treatment.

Outcomes of family-centered treatment include individual outcomes, relational outcomes, and system/societal outcomes. Family-centered treatment results in improved treatment retention/outcomes for individual women as well as improved outcomes for children and other family members. Relational outcomes include improvements in parenting, family functioning, the number of families reunified or remaining intact, and improved communication. On a community and societal level, family treatment offers the opportunity for families to transform from being heavy users of services and resources to being productive, contributing community members. As families transform, parenting improves, resulting in further improvements in child well-being; communication improves, family norms shift, and economic and social well-being can increase.

I. INTRODUCTION

Across cultures, the family unit is recognized as the cornerstone of society. Families serve as the basis for most households, as economic units, as well as providing child-rearing, human interactions, and cultural traditions. Yet, families are complex in their definitions, roles, responsibilities, and interactions. In *What Is a Family?* Edith Schaeffer (2001) compares the family with a mobile. She writes:

What is a family? A family is a mobile. A family is the most versatile, ever-changing mobile that exists. A family is a living mobile that is different from the handcraft mobiles and the art-museum mobiles. . . . A family is an intricate mobile made up of human personalities. . . . A mobile is a moving, changing collection of objects constantly in motion, yet within the framework of a form. The framework of a family gives form. . . . A family is a grouping of individuals who are affecting each other intellectually, emotionally, spiritually, physically, psychologically. No two years, no two months, or no two days is there the exact same blend or mix within the family, as each individual person is changing. If people are developing in a variety of creative areas, coming to deeper understanding spiritually, adding a great deal of knowledge in one area or another, living through stimulating discoveries of fresh ideas or skills—they are affecting each other positively. . . . mobiles that can reproduce. Constantly changing patterns, affected by each other, inspired by each other, helped by each other. (pp. 17–22)

Substance use by one family member affects the whole family mobile. When a parent has a substance use disorder, it can corrupt the harmonious spinning of all of the parts, break some of the strings that tie the mobile together, and fracture individual sculptures as they fall. Substance use disorders are family diseases because there can be an intergenerational transmission that affects the entire family unit and its individual members. Family-centered treatment promotes the delivery of comprehensive services that can transform these families into healthy, functioning entities that can raise children, reach their economic goals, and support the well-being of all members. Family-centered treatment offers a solution to the intergenerational cycle of substance use and related consequences by helping families reduce substance use and improve child health and safety.

Snapshot of Families Affected by Substance Use Disorders

Approximately 6 million children younger than age 18 lived with at least one parent who was dependent on alcohol or an illicit drug during 2002 (Office of Applied Studies, 2003). Two-thirds of these children lived in families in which at least one person had alcohol dependence. Attachment 1 provides additional data on parental alcohol and illicit drug use, the need for substance abuse treatment, and treatment availability.

Parental substance use increases the likelihood that a family will experience financial problems, shifting of adult roles onto children, child abuse and neglect, violence, disrupted environments, and inconsistent parenting. Research shows that a complex and harmful cycle exists in which a history of child abuse and neglect increases a person's risk of later substance use and that

individuals with substance use disorders are more likely to abuse or neglect their children (CSAT, 2004). Children of parents with substance use disorders have a significantly higher likelihood of developing substance use problems themselves (CSAT, 2005; Price & Simmel, 2002; Young, Gardner, & Dennis, 1998).

An estimated 5.5 percent of women ages 18 to 49 who have one or more children living with them are dependent on alcohol or illicit drugs (Office of Applied Studies, 2005b). Seventy percent of women and 50 percent of men entering substance use treatment report having children (Brady & Ashley, 2005). Thirty percent of the 13,464 treatment programs in the United States offer special programs or services for women, and 14 percent offer programs for pregnant women (Office of Applied Studies, 2004c). Research shows the importance of engaging families in services. More than three-fourths of women participating in the Residential Women's and Children's Program and the Pregnant and Parenting Women's Program (RWC/PPW) reported that their families were involved in alcohol- or drug-related activities. Almost half of them (42.9%) reported having fewer than two friends who did not use drugs (Conners et al., 2004).

Although alcoholism and drug addiction have long been recognized as family diseases, treatment approaches until recently have remained primarily focused on helping the individual with a substance use disorder. Adolescent treatment and pregnant or parenting women's treatment are two different entry points in which family-centered treatment is emerging. Families may enter treatment through either of these "doors." Both these entry points hold one individual household member as the "primary client" and other family members as additional "co-clients" whose needs are also addressed. In pregnant or parenting women's services, family treatment has the substance-using woman at the core, whereas in adolescent family treatment, the adolescent with the substance use problem is the primary focal point. Other family members are brought in, and family dynamics and needs are addressed with the primary goal of helping the primary substance user. In adolescent services, brief strategic family therapy (BSFT) is proving effective in helping families address adolescent substance use. This approach has been implemented with families without parental substance use or with low to moderate use; however, counselors generally create boundaries to disengage adolescents and other family members who do not use substances from a parent who is substance dependent, and counselors do not address the parent's substance use disorder (Szapocznik, Hervis, & Schwartz, 2003). Likewise, women's treatment providers tend to seek involvement of supportive family members and discourage relationships with other higher need family members. As agencies begin to implement family-centered treatment for both parents and adolescents with substance use disorders, the effectiveness of the approach for the highest need families can be evaluated.

Some clinicians posit that the lack of attention to the importance of relationships and the roles women play in families and of accompanying family services may contribute to reduced treatment access and retention and increased relapse among women. Family demands prevent many women who use substances from seeking or completing treatment. These women may not have adequate resources to care for children or other family members for whom they are responsible. They may fear that if they admit to having a substance use problem, their children will be removed from their care.

Relationships of all kinds are of critical importance to most women. In addition to the importance of the relationships with their children, many women with substance abuse or dependence may be conflicted when they have partners who resist their recovery. Boyfriends, partners, and spouses often encourage girls' and women's initiation of use, discourage women from entering treatment, encourage continued drug use, provide drugs, and enable relapse. Having a support network greatly increases treatment retention and reductions in drug use for women (Brady & Randall, 1999; Grella, Scott, & Foss, 2005; United Nations Office on Drugs and Crime, 2004). Nevertheless, traditional substance use treatment facilities have provided limited support for families. Family involvement has often been restricted to "family groups" that continue to place the individual with a substance use disorder (traditionally the father) at the center and help educate families on the recovery needs of that family member.

Most cultures use a collective vision of family in which extended family members are interdependent and work together to raise children, provide for economic needs, and meet family obligations. For instance, research on Afrocentric, Latino, Native American, Asian, and rural family systems emphasizes the role of extended family (Bent-Goodley, 2005; Boyd-Ball, 2003; Santiago-Rivera, Arredondo, & Gallardo-Cooper, 2002; Stewart, 2004). Likewise, many women who are substance dependent have an extended family network that helps address the family needs (Brady & Ashley, 2005; Connors et al., 2004). Blended families are often common; step-parents, significant others, and half-siblings are often included in family networks. Although spouses and fathers of children play a special role, family is not limited to nuclear families. Family-centered treatment can include grandparents, godparents, and other extended family members beyond the nuclear family.

Although families are considered the central unit of society, the health and social service delivery systems, including those for alcohol and drug treatment, have been designed for individuals. States have differing systems for delivering substance use disorder treatment; some use managed care, county systems, or direct treatment services. The services available, however, are based on the Institute of Medicine continuum of care and the American Society of Addiction Medicine Patient Placement Criteria. Regulations, Medicaid, and other funding requirements further govern the service delivery system. State implementation of the National Outcome Measures will shape reportable outcomes. All these systems are currently designed for individuals, not families. Across the country, the mechanisms for client identification and placement, funding, and evaluation are based on the needs of individuals with substance use disorders. There are some new efforts to better integrate family decision-making and family involvement in other fields as well. For example, schools are increasingly including family resource centers; and mental health and public health programs (e.g., obesity prevention) are working on family engagement strategies. Child welfare services are also moving toward a family decision-making model, and there is an increase in family drug courts. Adoption of family-centered treatment, beyond pilot programs, will require the field to come together and develop instruments and protocols that address families.

About This Paper

The purpose of this briefing paper is to present a continuum of family-based services and to introduce, define, and discuss family-centered treatment as a newly evolving approach to addressing substance use disorders. Challenges related to implementing comprehensive family-centered treatment services for families with parental substance use are also discussed. This

paper brings together the necessary background, context, and framework that policymakers, funders, and treatment providers need in order to develop and expand family-based services and family-centered treatment services for families with parental substance abuse and dependence.

In July 2005, SAMHSA's CSAT, in conjunction with the Rebecca Project for Human Rights, held A Practice-Based Symposium on Comprehensive Family-Centered Treatment. This symposium brought together experts on family-based services for a conversation on family-centered treatment, barriers to its implementation, and strategies for overcoming these barriers. (See Attachment 2 for a list of participants in the symposium.) The symposium provided expert insight for this briefing paper. In addition, an extensive literature search and review, drawing from research on both family-support models and substance use treatment, was conducted.

Family-centered treatment is an emerging service approach to address the needs of two distinct target populations: 1) pregnant and parenting women with substance use disorders and 2) adolescents with substance use disorders. Within each target population, a family-centered treatment approach has been developed that is independent of the other. Overlaps in population, interventions, outcomes, and challenges, have not been explored and are beyond the scope of this paper. This paper, and the expert symposium that informs it, focus on family treatment when a mother with a substance use disorder comes to a point of entry. Services for children and adolescents are addressed but within the context of the family of the mother in need of treatment interventions.

Sections I and II of this paper provide background and introduce a Continuum of Family-Based Services. This continuum defines different types of family-based services on a continuum through a progression that ranges from services for adults with substance use disorders that involve aspects of family dynamics on one end of the spectrum to the integration of comprehensive treatment for adults with substance use disorders, their children, and other family members at the other end of the spectrum. Sections III through VI explore family-centered treatment, the more in-depth, comprehensive services on the spectrum. Section III defines family treatment including common principles, characteristics, and components of family-centered treatment. Section IV explores the different ways in which family-centered treatment can be provided through a range of collaborative and service methods. Service delivery models are discussed in terms of their potential for reaching, retaining, and supporting families affected by parental substance use disorders. Section V discusses challenges to the delivery of family-centered treatment, including programmatic and administrative considerations. Finally, Section VI summarizes the discussion and offers some possible next steps for reducing barriers to family-centered treatment and improving outcomes for families affected by substance use disorders.

II. EVOLUTION OF A CONTINUUM OF FAMILY-BASED SERVICES

The past 30 years have seen the emergence of treatment and services for women with substance use disorders. First, women were served in men's programs, using male-dominated models. In the 1970s, women-specific services emerged; however, the approaches remained based on treatment strategies effective for men. Significant funding and development efforts by SAMHSA, the National Institute on Drug Abuse, and the National Institute on Alcohol Abuse and Alcoholism have produced a body of evidence on the specific nature of women's substance use and related treatment interventions.

Although a few programs for women with children emerged in the 1970s, family-based services grew out of the residential programs for pregnant and parenting women that developed in the early 1990s. SAMHSA established the Residential Women's and Children's Program and the Pregnant and Parenting Women's Program (RWC/PPW), which funded the development of model programs. These programs were designed to provide services for women with their children. The concept was that these women could continue to meet their parenting responsibilities, bonding with children would be protected, child care would be provided, and these activities would allow for the women's participation in treatment. The early programs learned that the children presented with significant therapeutic needs of their own. They also found a high incidence of poor parenting skills and minimal attachment ability in many of these families. Programs struggled to meet the array of unexpected needs of children and families.

Although some programs served all families, regardless of the number or age of children, most of these early programs placed limits on the number and ages of children. These limits were placed for logistical, milieu, and clinical reasons. In most programs, older children, fathers, domestic partners, and other family members received no services or limited services. These individuals were often not included in a healing process, frequently with the result of only partial family recovery and limited support for the women as they left treatment. For some families, the treatment caused divisions that actually created new problems and further rifts in family functioning.

For more than 10 years, programs have struggled with the financial, programmatic, and policy barriers to serving whole families. Some have successfully overcome such hurdles and show promising results (CSAT, 2001; Jackson, 2004; McComish et al., 2003; Metsch et al., 2001; Price & Simmel, 2002). New opportunities are creating momentum to expand family-based services. These include

- Increased recognition of the need
- Skill and success in collaboration across service systems
- Increased awareness of the effect of parental substance use disorders on children
- Renewed attention to the importance of family
- Research showing the importance of relationships and family for women's recovery support
- A broadened understanding of multidisciplinary and integrated services

Family-centered treatment meets the need for parental treatment for substance use disorders and the need for support services for family recovery.

Table 1 depicts the Family-Based Services Continuum. All types of services identified in this table support family members and family involvement. Programs that offer no family-based services or that do not recognize the significance of family in treatment outcomes are not included in this continuum. The continuum describes five different levels of family-based services. The levels range from family involvement—a minimum standard of service—through family-centered services to comprehensive family-based treatment—the most comprehensive level. Programs fall along this continuum, depending on who is welcome and the services they receive. Table 1 identifies a title, core components (what), participants (who), and anticipated outcomes (outcomes) for each of five levels.

The continuum provides a framework and definition that allow for a more in-depth discussion of family-based services. Although expert panelists at the symposium acknowledged the importance of defining terminology, they also noted that the terms used to describe services vary and must remain flexible because meanings vary across collaborative agencies and because funding streams often use strictly defined categories and terminology.

At one end of the continuum, Level 1, are women's treatment programs that focus primarily on the individual but address family relationships as an integral part of the treatment process. Level 1 programs serve women who may or may not have children, single women, senior women, young women, pregnant women, women who have lost custody of their children, and women whose minor children are with other caretakers. Although services focus on the women, these programs are included on the family services continuum because their services are delivered in a manner that recognizes the importance of families and relationships.

Continuum Level 2 programs serve women who are accompanied by their children. Although the focus is on women, these programs provide child care and other basic services to the children, with the primary goal of supporting women's treatment and recovery. Treatment (or case) plans are developed for the women only. These plans may have objectives related to parenting and family relationships. However, the program does not specifically address the service needs of the children. Parenting classes may be offered but not family counseling. These programs allow women to attend treatment while caring for their children.

Continuum Level 3 programs, Women's and Children's Services, emerged as the RWC/PPW programs found that more child- and family-based services were needed in most client families. Level 3 programs address children's service needs including developmental delays, prenatal substance exposure, and emotional issues. Mothers and children all have treatment (or case) plans. The programs actively engage parents to develop parenting skills and their ability to address the complex needs of their children. For children in the child welfare system, Level 3 programs can serve a dual role: supporting their mothers toward abstinence and improved parenting and ensuring the health and safety of children. These programs offer services for both women and their children. Often Women's and Children's Services programs limit the number or ages of children, and services for additional family members are not available.

Continuum Level 4, Family Services, provides for treatment (or case) plans for women and their children, as described in Level 3. In addition, the children's fathers, significant others, or other family members receive services to support the women's recovery. These participants do not have treatment plans of their own; however, they participate in counseling sessions and

program supports that result in a more effective family system and a more supportive environment with relationships that encourage ongoing abstinence for women with substance use disorders.

Finally, Continuum Level 5, Comprehensive Family-Centered Treatment, provides services for women who use substances, their children, and the children's fathers or other family members. All members of the family have individualized case plans and share an integrated family plan. Male partners with substance use disorders access their own treatment services (possibly in a different location or in a program different from that of mothers); family counseling, employment, and reentry services are among the services that may be provided. In addition, children, often with behavioral or emotional problems of their own, receive individualized services.

Table 1. Family-Based Services Continuum for Women with Substance Use Disorders

					
Family involvement			Family-based treatment		
Level	1	2	3	4	5
What	Women's Treatment With Family Involvement	Women's Treatment With Children Present	Women's and Children's Services	Family Services	Family-Centered Treatment
Who	Services are provided to women including pregnant women and women with or without children. Individual is the focus of intervention. Services are offered in context of family relationships. Women may have limited family education, counseling, or visitation.	Women are at center of treatment but have children with them. Program provides for child care and basic needs but no service plan for children. Children's presence is primarily to support women's participation in treatment.	Women bring children to treatment. Women and each child have case plans and receive services. Parenting support and parenting skills provided. Some children and other family members may be excluded.	Programs provide women's and children's services with some other family members' services to support women's recovery. Women and children have case plans, but fathers and other family members do not.	Women, children, fathers, and other family members all participate and all have case plans. Family unit is supported in communication and decision-making.
Outcomes	- Improves outcomes for women compared with programs without family context. - Allows women whose children have been removed to meet court requirements. - Improves birth outcomes over programs without family context.	- Allows for visitation. - Allows for parent/child attachments to continue. - Provides for safety of children. - Having children helps motivate mothers toward recovery. - Increased reunification.	- Improved treatment retention/outcomes for women. - Early screening/intervention for developmental delays. - Increased reunification. - Improved child outcomes. - Improved parenting & family functioning.	- Improved treatment retention/outcomes for women. - Further improved child outcomes. - Limited improved outcomes for other family members. - Further improvements in parenting & family functioning.	- Family transformation (improved parenting and increased family functioning). - Improved treatment retention/outcomes for women. - Improved outcomes for all family members. - Increased percentage of families remaining intact. - Further improved child outcomes.
					
As more members of the family are present and able to access services, the potential for improved short- and long-term outcomes for all members involved increases.					
Fathers	Men's treatment with some family groups and family issues addressed in treatment.	Fathers and their children with them but no therapeutic services or case plans for children.	Fathers and their children receiving services.	Fathers and their children with some other family member services to support the fathers' recovery.	Whole family services with male who abuses substances as center of family.

III. FAMILY-CENTERED TREATMENT DEFINED

Family-centered treatment is a comprehensive strategy that addresses the biopsychosocial-spiritual nature of substance use disorders. It is a highly individualized, gender-responsive treatment of substance use disorders for women. Gender-responsive treatment is predicated on the distinctive characteristics of the female physiology and women's roles, socialization, experiences, and relative status, in the larger culture. Gender-responsive treatment is trauma informed, strengths based, and relational (Grella, 2004). For treatment to be responsive to women also requires that the focus of treatment is organized around maintaining affiliations and creating healthy connections to others, especially children and other family members. Such treatment provides a full range of services to address the array of problems women with substance use disorders, their children, and other family members must tackle to reduce substance use and improve individual and family outcomes.

A mother with a substance use disorder is the core client of family-centered treatment programs, with her children and other family members as co-clients. Women entering treatment are more likely to have responsibility for dependent children. Although there are a few families in which fathers are the primary caretakers of children, and therefore are the core clients for family-centered treatment services, this is atypical. Most children of men who use substances have another primary caretaker (typically their mothers) (Brady & Ashley, 2005). It should be noted, however, that children can also be a motivator for treatment for involved fathers (McMahon et al., 2005).

Characteristics and Principles

Some common characteristics and principles underlie family-centered treatment and result in its unique mode of service delivery.

- **Family-centered treatment is comprehensive.** Family-centered treatment includes clinical treatment, clinical support, and community support services addressing substance use, mental health, physical health, and developmental, as well as social, economic, and environmental needs for women and their families.
- **Women define their families.** Family is inclusive of the supportive network of relatives and others whom the woman identifies as part of her family. Treatment can focus on healthy attachment and relationships between parents and children and on women's relationships with others. Family-centered treatment helps a family function as a unit.
- **Treatment is based on the unique needs and resources of individual families.** The goals, interventions, type, length, frequency, location, and method of services vary depending on the strengths and needs of the family members.
- **Families are dynamic, and thus treatment must be dynamic.** Treatment must be able to address evolving and changing family engagement. Everyone may not participate at the same time, stay the same length of time, or have the same motivations.
- **Conflict is inevitable, but resolvable.** Multiple crises are the norm, not the exception. Families must juggle conflicting needs and priorities and balance the needs of members.

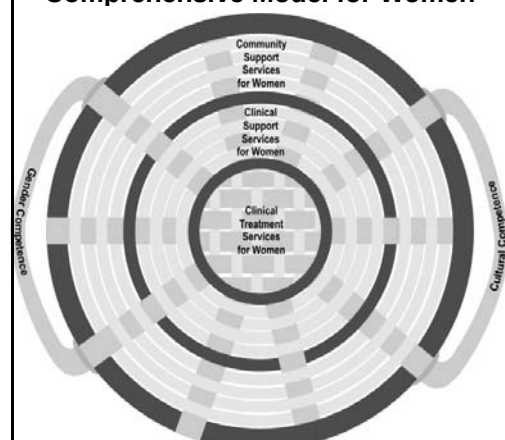
- **Meeting complex family needs requires coordination across systems.** Most families with substance use disorders are involved in multiple service delivery systems (e.g., child welfare, health, criminal justice, education). Coordination and collaboration prevents conflicting objectives and provides optimal support for family members.
- **Substance use disorders are chronic, but treatable.** The treatment process is not an event but rather a gradual process that moves individuals and families toward lasting recovery. Treatment includes a broad continuum of programs and strategies designed to address dependence, ameliorate adverse consequences associated with substance use, return biopsychosocial functioning and reduce/eliminate substance use. Behavioral therapies, motivational enhancements, pharmacological interventions, and case management are common elements of treatment.
- **Services must be gender responsive and specific and culturally competent.** Services must be grounded in and use the knowledge and skills that fit the background of individuals and families. Gender-responsive services recognize the unique characteristics of women's initiation of use, effects of use, histories of trauma, co-occurring mental health and physical disorders, and other treatment issues including the primacy, importance, and continuity of relationships in women's lives. Culturally competent services are embedded in the language, values, and experiences of a client's culture.
- **Family-centered treatment requires an array of staff professionals as well as an environment of mutual respect and shared training.** Organizational cultures that encourage learning, a team approach, and consultation are necessary for diverse staff members to work together.
- **Safety comes first.** Maintaining a safe environment for all family members, in all client families, is essential. Programs must have policies for addressing inappropriate behavior in children, youth, and adults and protecting confidentiality. Maintaining trauma-informed and trauma-sensitive services and treatment milieu is of paramount importance.
- **Treatment must support creation of healthy family systems.** Healthy family systems include structure, appropriate roles, and good communication that allow the family to function as a unit while concurrently supporting the needs of each individual member.

Components of Family-Centered Treatment

In 2004, CSAT's Women, Youth and Families Coordinating Committee revised the CSAT Comprehensive Substance Abuse Treatment Model for Women and Their Children (Comprehensive Model) to include three inter-related rings of services offered within a context of cultural competence, gender competence, and developmental appropriateness (Attachment 3). These primary types of services are clinical treatment, clinical support, and community support.

Family-centered treatment expands CSAT's Comprehensive Model that identifies the components

Figure 1: Interrelated Elements of the Comprehensive Model for Women



necessary for quality services for women and their young children to include older children, fathers, husbands, partners, and other family members. Individualized screening, assessment, and case planning occur for each member of the family. All services are also provided in a family context, and whole family support and services are also provided.

Women's Services

The primary objective of the family-centered treatment services described here is to improve outcomes for women with substance use disorders, their children, and other members of their families. To accomplish this objective, a program must have a strong core that includes approaches, interventions, and services that are effective in reaching and retaining women. Gender-responsive programs consider the needs of women in all aspects of program design and delivery, including location, staffing, program development, program content, and program materials (United Nations Office on Drugs and Crime, 2004). Gender-responsive programs offer more than a set of relevant services for women; they provide safe and comfortable environments in which women develop supportive relationships that allow them to address their recovery needs (Covington, 2006).

In the Comprehensive Model, **clinical treatment services** are defined as services necessary to address the medical and biopsychosocial issues associated with addiction, including the following

- Outreach and engagement
- Screening
- Detoxification
- Crisis intervention
- Assessment
- Treatment planning
- Case management
- Substance abuse counseling and education
- Trauma services
- Medical care
- Pharmacotherapy/Medication assisted treatment
- Mental health services
- Drug monitoring
- Continuing care

Clinical support services for women assist clients in maintaining their recovery. Clinical support services include

- Life skills
- Parenting and child development education
- Family programs
- Educational remediation and support
- Employment readiness services
- Linkages with legal and child welfare systems
- Housing support
- Advocacy
- Recovery community support services

The third primary type of services, **community support services**, is discussed later.

Children's Services

Child development occurs along a continuum including prenatal/birth/newborn (0 to 1), toddler/preschool (2 to 5), middle childhood (6 to 12), and adolescent (13 to 18). Each of these

developmental phases brings specific tasks and challenges to the developing child. For example, brain development occurs at the fastest rate throughout the prenatal and toddler stages. Critical social-emotional developmental tasks occur in infancy as a child bonds with his or her caregivers and develops secure attachments. The preschool child has unique challenges to acquire language and cognitive skills and develop autonomy and appropriate social behaviors, while physical and motor skills are advancing. Middle childhood brings increased physical challenges and cognitive maturation. A major transition in this phase occurs as children adapt to the educational environment and new peer influences in their widening social circle. In adolescence, cognitive development lends itself to advancing the individual's moral development and ability to reason. Youth seek independence and identity, while lacking the full executive function and control of impulsivity of adults. As a result, adolescence is an increasing time of exploration, risk taking, and sexual experimentation.

The effects of substance use disorders on children and families are significant and well documented (Besharov, 1994; Conners et al., 2004; Department of Health and Human Services, 1999; Young, Gardner, & Dennis, 1998). Children of people who abuse substances are likely to have a range of developmental, behavioral, and emotional difficulties. Early intervention in these problems supports optimal development of the children, improved outcomes for their families, and ultimately reduced costs and increased productivity for the community. Engagement and treatment for pregnant women can result in improved birth outcomes including delivery of drug-free infants and babies with better birth weights (Conners et al., 2004; CSAT, 2000). Integrating children into parental substance use treatment changes the treatment dynamic and offers an integrated way of addressing the needs of families with multiple problems.

As residential programs for women with children were established, providers found that simply keeping the children with their mothers was inadequate. Many children needed therapeutic, health, developmental, and other services to address specific delays and conditions. Most of the mothers had significant weaknesses in their parenting skills that contributed to poor attachment, esteem, and development for the children. The families had not developed the cohesive family systems that provide the security, support, and interaction that members need. This in turn contributed to the feelings of guilt and inadequacy of the mothers, because they build their sense of identity and self-esteem on being adequate parents and maintaining harmony in the family. Early programs scrambled to find the necessary resources to improve parenting, reduce external stressors, and meet the clinical treatment and support needs of the children.

Lester and his colleagues (Lester, Andreozzin, and Appiah, 2004) describe three types of consequences of maternal use of alcohol, tobacco, and illegal drugs (MATID) on child development:

- *Immediate drug effects*—the direct teratogenic consequences of MATID exposure occurring during the first year prior to postnatal environmental effects becoming salient
- *Latent drug effects*—also direct teratogenic effects that affect brain functioning but do not become relevant until later in development
- *Postnatal environment effects*—environmental factors such as sociodemographics, caregiving context and style, and caregiver characteristics (both risk and protective factors)

Prenatal exposure to alcohol and other drugs, combined with postnatal environmental factors, can result in increased developmental, physical, cognitive, and emotional challenges (Young, 1997). Fetal alcohol syndrome (FAS) is a major preventable cause of mental retardation. Fetal Alcohol Spectrum Disorders (FASD) describes individuals with FAS as well as those with behavioral, cognitive, and other deficiencies who do not have the physical facial abnormalities of individuals with FAS. FASD is not a clinical diagnostic term but refers to the following conditions: FAS, alcohol-related birth defects, and alcohol-related neurodevelopmental disorder. Alcohol-related birth defects can include abnormalities of the heart, eyes, ears, kidneys, and skeleton (e.g., holes in the heart, underdeveloped kidneys, fused bones). Children with FASD may have physical health problems, impairments in global functioning, executive functioning, auditory processing, visual/spatial skills, memory or attention. Infants exposed to alcohol, tobacco, and illicit drugs in utero are more likely to be premature and of low birth weight. Infants and children who are exposed to substances appear to have higher levels of activity (and possibly hyperactivity), other behavioral and learning problems, and impaired psychosocial functioning (Roebuck, Mattson, & Riley, 1999). Children who are prenatally exposed may exhibit delayed developmental outcomes (physical, intellectual, social, and emotional) in comparison with other children; however, they typically score in the low-normal range of developmental measures rather than the impaired range (Lester, La Gasse, & Seifer, 1998; McMahon & Luthar, 1998).

Infants born exposed to drugs may experience neonatal withdrawal. Symptoms may include fussiness, trembling, poor eating and sleeping. Neonatal withdrawal usually occurs within the first 48 hours but can last for up to two weeks. Babies born to mothers on methadone maintenance may experience neonatal withdrawal syndrome, however, their health is comparable to the general population and significantly better than those that continue to be exposed to heroin.

Prenatal exposure is one of many contributing factors that influence an infant's developmental, physical, cognitive, and emotional growth. The effect of prenatal exposure to alcohol and drugs is contingent on the frequency, duration, and severity of the mother's substance use. Other factors such as the mother's overall health and genetic predisposition may also influence the infant's outcomes. Furthermore, these developmental trajectories are influenced by other factors such as child abuse and neglect, unstable and inconsistent care-giving, family and community violence, lack of positive adult role models, and other adverse life events. Early identification and intervention can reduce related environmental problems while simultaneously promoting optimal health and development for these children.

Following are seven areas in which children of substance using parents may have problems:

- *Physical Health Consequences* (e.g., premature or low birth weights, lengths, and head circumferences; alterations in fetal brain development; poor pediatric care; increased vulnerability to acute and chronic health problems or poor health care management) (Kronstadt, 1991; Sher, 2004)
- *Lack of Secure Attachment* (e.g., less securely attached to their caregivers) (Kronstadt, 1991)
- *Psychopathology* (e.g., attention deficit disorder [ADD] and attention deficit/hyperactivity disorder [AD/HD], anxiety, depression, and somatic complaint; may appear passive and apathetic) (Chasnoff et al., 1998; Delaney-Black et al., 2000; Goldschmidt et al., 2004; Jacobson and Jacobson, 2003; Lester et al., 2004)

- *Behavioral Problems* (e.g., poor internal controls; lack of tolerance for frustration or stress; difficulty delaying gratification; easily distracted; impulsive behavior; trouble focusing attention; difficulty organizing behavior; inappropriate behaviors to express their wants, needs, and fears; conduct disorder; oppositional defiant disorder; delinquency) (Chasnoff et al., 1998; Kronstadt, 1991; Lester et al., 2004)
- *Poor Social Relations/Skills* (e.g., poor social skills and adjustment; problems with peers; deficits in interpersonal relations; poor development of moral reasoning, social judgment, and interpersonal skills; aggression; difficulty sustaining relationships; over-controlling; antisocial behavior) (Jacobson & Jacobson, 2003; Schonfeld, 2003)
- *Deficits in Motor Skills* (e.g., difficulties with gross or fine motor skills, poor handwriting) (Lester et al., 2004)
- *Cognition and Learning Disabilities or Learning Problems* (e.g., delayed receptive and expressive language development, difficulties with expressive language, articulation, literal understanding with poor decoding of figurative language and metaphors, difficulty in filtering out stimuli, performing poorly on memory and verbal tests, impairments in executive functioning, poor task organization and processing, poor academic skills) (Kronstadt, 1991)

Because families that are involved with substance use are often isolated, symptoms can go unnoticed. Developmental delays and other problems often remain unidentified and untreated until children enter school or later. Parental drug treatment, in which parents feel secure and trust the care provider, provides an ideal time to assess children, identify their therapeutic needs, and provide services accordingly. This is especially true in residential and day treatment programs where children are receiving child care and other services onsite.

Pediatric HIV cases have been dramatically reduced as a result of effective drug therapy (AZT-based regimens) and prenatal care (HRSA, 2006). Perinatal transmission of HIV is a risk for infants born to HIV positive women who do not receive care. These infants and children will require specialized health care, must cope with uncomfortable side effects of medications, face unique psychosocial challenges, and have a shorter life expectancy.

For older children and youth, the array of services ideally provides for their physical, emotional, and social needs. Some older youth demonstrate high resiliency and appear not to need significant intervention services. These youth, as well as those who present with more observable symptoms of childhood trauma, should be assessed for a range of supportive service needs. Some older children need the opportunity to play and explore without the responsibility of caring for the family. Other youth present with different problems including delinquency, poor peer relationships, academic failure or low performance (often caused by school disruptions, lack of a suitable homework environment, and truancy), anger and violent outbursts, trauma, inappropriate sexual boundaries, behavioral problems, young sexual encounters and pregnancy, conduct disorders, AD/HD, learning disabilities, or poor social skills.

Programs for older youth at the RWC and family-centered treatment programs included counseling groups, afterschool programs and tutoring, special education advocacy, art therapy, recreational activities, substance abuse prevention, and employment assistance. A range of services for common presenting problems and referrals or linkages and case management for other services combined with improved parenting help restore family cohesion, redirect behaviors, and improve the coping skills of these high-risk youth. In addition to needing

treatment services for the mother, some families have substance-abusing or -dependent youth who may also require engagement and substance use disorder treatment services. Concurrent treatment with family-based services provides the opportunity for the family members to make whole-family adjustments that can support the recovery of all members with substance use problems. Mothers will be more effective participants in their children's substance use treatment if they are also addressing their own treatment needs.

The Comprehensive Model includes culturally and developmentally appropriate clinical treatment and clinical support services for children. These are more fully described in Attachment 3.

Clinical treatment services for children include

- Screening
- Intake
- Assessment
- Medical care and services
- Residential care (in residential settings)
- Case management
- Case planning
- Substance abuse education and prevention
- Mental health and trauma services
- Therapeutic child care and development

Children's clinical support services include

- Onsite or nearby child care
- Mental health and remediation services
- Prevention services
- Recreational services
- Educational services
- Advocacy
- Recovery community support services

Fathers, Partners, and Other Family Members

The same services offered to women in the Comprehensive Model (see Women's Services, above) should also be available for fathers, partners, and other immediate family members. Research on substance use disorders in families suggests that, in many cases, other family members are likely to have substance use or mental health problems (Conners et al., 2004; Price & Simmel, 2002). In other instances, family members may be functioning fairly well and need only minimal support, such as education about substance use and family services. The particular needs and priorities will vary among families. Expert panelists at the CSAT Practice-Based Symposium on Comprehensive Family-Centered Treatment indicated that outreach and engagement services are critical to the success of family treatment services. Providers serving families identify specific outreach, engagement, assessment, and case plan needs for each individual family member depending on each individual's needs, role in the family, and strengths. Services may include alcohol and drug education, support groups, crisis intervention, counseling, life skill development (e.g., anger management, communication), employment assistance (e.g., education, job training, job placement), substance use treatment, health services, mental health services, case management, and advocacy.

Whole Family Approach

In addition to the services it offers to individuals, family-centered treatment offers whole family services that build on family members' strengths to improve family management and functioning. The family-centered treatment process offers families a structure for interactions that aids in role identification, boundary clarification, and addressing external stressors and areas of concern. The role of service providers is not to "fix" the family but to address the whole family system and assist members in developing the communication, power, boundaries, roles, flexibility, and cohesion they need to create a healthy family ecosystem. These activities involve developing successful family coping strategies—assisting families in identifying and responding (rather than reacting) to the effect of transitions.

Parenting

Most parents with substance use disorders have been inconsistent in their child rearing. Addressing children's needs, becoming more interactive and engaged with children, and accepting the subtle successes of parenthood are not easy tasks. When a woman has experienced a history of childhood abuse and trauma, it can result in parenting problems as well as contribute to her substance use disorders. Developing satisfying relationships with their children, increases parents' motivation to abstain from drug and alcohol use (Collins, Grella, & Hser, 2003). Treatment programs assist family members in establishing and maintaining a schedule, a structure, regular habits, and healthy rituals. Family-centered treatment programs usually offer parenting classes in which parents increase their knowledge of child development and improve their skills for addressing the needs of children of different ages.

SAMHSA's Center for Substance Abuse Prevention has research-based models of parenting interventions in the National Registry of Evidence-Based Programs and Practices (<http://www.nrepp.samhsa.gov/>). The Office of Juvenile Justice and Delinquency Prevention identified model programs available through the Model Programs Guide through the Strengthening Families Initiative (http://www.dsgonline.com/mpg2.5/mpg_index.htm). Family-treatment programs also offer role modeling, mentoring, and ongoing opportunities for staff members to engage parents in quality interactions. By having a multidisciplinary team available, family-centered treatment agencies can meet the diverse needs of clients as they arise. There are many teachable moments when a staff member can model or support a parent in using newly acquired coping or parenting skills. As they practice, parents build esteem, and they begin to see results in improved behavior and increased enjoyment with their children (Jackson, 2004).

A range of family support, preservation, reunification, and maintenance services can be provided in family-centered treatment centers for families with current child welfare cases. With the narrow timeframes for reunification or termination of parental rights, concurrent drug treatment and parenting support are necessary for a family to succeed in retaining parental rights in a timely manner. Provision of family-centered treatment provides a supervised environment that increases child safety, allows for concentrated service delivery, and provides opportunity for ongoing assessment of child well-being. By involving other family members, not just mothers, family-centered treatment providers can create an improved support system that

continues as families leave residential treatment. Family-level services enable conflict resolution and joint planning between the parents and other family members including those who serve as important caretakers for children.

Family and Relationship Counseling

Family and relationship counseling facilitates improvements in relationships (CSAT, 2005; Price & Simmel, 2002). Relationship counseling can help a couple identify the strengths and problems in their relationship, process past problems, and identify how to continue or improve their relationship. Family counseling and family therapy allow the family to shift roles so that a parent can assume a parenting role. It helps build family structure, cohesion, bonding, and trust.

Couples with a history of domestic violence should not be provided with relationship counseling or family counseling until after each partner has received individualized services. Research indicates that in violent families, couples counseling may exacerbate violence (CSAT, 2000). Careful individualized assessment and safety planning must be conducted before involving families with a history of domestic violence in family-centered services.

Community and Recovery Support Services

Family-centered treatment integrates community and recovery support services for families. For many families with substance use disorders, these services are critical for establishing a drug-free lifestyle and improving economic and social well-being for children and families. Poverty, stigma, and poor employment prospects challenge families as they return to the community. Community support services are provided in the community as part of the support system for the recovering family.

Community support services are identified in the Comprehensive Model and include

- Recovery management and recovery community support services
- Housing that encourages alcohol- and drug-free living
- Ongoing family-strengthening services
- Child care
- Transportation
- TANF linkages
- Recovery support and substance abuse prevention in the workplace
- Vocational and academic education services
- Connections to faith-based organizations as appropriate and desired

Ongoing recovery support is essential for families with substance use disorders to make the changes necessary to adopt an alcohol- and drug-free lifestyle. Family-centered treatment includes assistance for women to develop a recovery support network, relapse prevention tools, and housing and community services necessary to improve economic and social well-being. When families enter recovery together, they can serve as resources for one another in maintaining lasting recovery. Participation in Alcoholics Anonymous, Narcotics Anonymous, Al-Anon, and other mutual-help recovery support networks is a valuable resource for many recovering families. The CSAT Recovery Community Services Program (RCSP) projects also offer peer-driven recovery support services in many communities. RCSP projects offer a

strengths-based and empowering approach to the development of recovery skills, assisted by members of the recovery community.

Family-centered treatment allows for one overall, integrated family plan that builds coherence and prioritizes the needs of individual family members. Decisions spanning issues such as appropriate housing, childcare and scheduling needs, employment goals, budgeting, and other daily life skills are integrated into a comprehensive plan aimed at helping a family establish itself as a functioning unit.

A comprehensive family plan provides coordination, recovery, and community support services and promotes family decision-making. It encourages the adult family members to come together in a structured way to set family goals, solve problems, and communicate, returning to or establishing healthy family norms. For most individuals with substance use problems and their families, developing a mutually supportive system for communication and decision-making offers a unique opportunity to create healthy family patterns. Few substance-involved families are able to initiate mutually supportive communication or decision-making without at least facilitation and training.

Comprehensive family-centered treatment addresses the individual, familial, and community-based challenges of substance use. Returning to the analogy of the family as a mobile, family treatment offers families the opportunity to mend themselves and begin to move together. Family treatment reties and reinforces the support strings holding individual members together as a unit, allowing them to both support and balance one another. Services must remain flexible and individualized as the composition, needs, and strengths of each family vary. By combining family support and substance use disorder treatment, programs provide the critical service components and environment most of these families need to recover and transform.

Outcomes

Family-centered treatment produces three levels of outcomes: individual, relational, and system or societal.

- **Individual outcomes.** Outcomes may include changes in substance use, employment, criminal behavior, and health status. These outcomes are measured by standardized instruments—for women, children, and other family members.
- **Relational outcomes.** Outcomes regarding parent-child relationship, family stability, attachment, relationship satisfaction, reunification, reduced violence, and parenting improvement. There are fewer accepted instruments or measures for relational improvements.
- **System or societal outcomes.** Outcomes such as employment rates and tax revenues generated by employment, reduced criminal recidivism and cost savings accrued to the criminal justice system, improved prenatal and birth outcomes and reductions in hospitalization costs for infants, and reduced use of other service systems. Evaluation of system outcomes is challenging.

On a program level, establishing outcomes and then measuring program effectiveness for meeting these outcomes help ensure that clients receive a good standard of care. Use of quality

assurance and quality improvement measures allows programs, funders, and evaluators to examine whether the program is offering a consistent and competent practice for all families, enables programs to examine where service delivery can be improved, and identifies strategies to improve these services.

Cost-Savings

There are some existing cost–benefit studies that can help make the case for family-centered treatment for parental substance use disorders. The cost evaluation for the PPW/RWC programs evaluated cost and savings for 1,768 individuals in treatment at 26 programs. Savings were measured for reduced welfare costs, crime, foster care, and low birth weight babies. The evaluation found that for every \$1 spent, there was \$3.71 in benefits. Costs associated with meeting the needs of alcohol- and drug-exposed infants are very high. Christopher Kalotra (2002) reviewed 35 studies and cost estimates for caring for alcohol- or drug- exposed children. The estimated cost ranged from \$750,000 to \$1.4 million in a lifetime for each child born alcohol or drug exposed. Cost-benefit analysis of services for pregnant women shows tremendous cost-savings relative to improved birth outcomes.

Cost–benefit analysis of treatment services, drug courts, and California's Substance Abuse and Crime Prevention Act of 2000 also demonstrate the efficacy of treatment (Gerstein et al., 1994; Longshore et al., 2006; National Drug Court Institute, 2005; U.S. Government Accountability Office, 2005). Evaluations often take only certain of the cost-savings into account such as cost savings in victimization and judicial costs that results from reduced recidivism. So, for example, the U.S. Department of Justice (Miller et al., 1996) developed cost projections for the costs associated with each incident of specific crimes including child abuse (\$60,000), drunk driving–no fatality (\$18,000), and burglary or attempt (\$1,400). Given these costs, it is logical to conclude that family treatment would result in more benefits than costs. Family treatment is likely to result in improved retention and therefore improved outcomes for a higher percentage of clients; but even if this were not the case, the cost savings associated with successful outcomes are so great that they would more than offset the costs related to families that do not experience such successful outcomes.

Family-centered treatment is likely to have additional benefits than our current service system for three primary reasons:

1. The family-centered treatment model will result in improved retention for women. Improving retention will result in improved treatment outcomes.
2. The family-centered treatment model will result in additional improved outcomes beyond those of other treatment programs. The family-centered treatment model allows for improved family environments, increases in support between family members, reductions in family dysfunction and breakup, and increased family skills.
3. The family-centered treatment model provides for early intervention and improved family functioning that results in substantial long-run cost savings because children will be more likely to become contributing members of society.

Table 2: Family Treatment Results in Future Cost-Savings

Criminal Justice

- Reduced recidivism and associated court, incarceration, parole/probation costs
- Reduced costs related to the current and future criminal activity of children
- Potential reduction in adult family member recidivism and associated costs

Employment and Poverty

- Employers save via reduced absenteeism from substance use, domestic violence, etc.
- Welfare rolls reduced through increased employability, job retention, and self-sufficiency
- Reductions in unemployment and/or lack of labor force participation, reducing community poverty
- Increase in family stability resulting in two-earner households caring for children, reducing poverty
- Improved future employability of children creates an improved U.S. workforce

Health

- Reductions in doctor- and hospital-related costs for births of alcohol- or drug-exposed infants (preterm births, low birth weights, other neonatal needs associated with exposure, maternal health needs) first-year medical costs of infants
- Reductions in costs associated with HIV, hepatitis C, other sexually transmitted diseases, and other health problems common among substance users
- Reductions in cost of meeting chronic and acute care needs of children and adults

Education

- Early identification and intervention to address developmental and learning difficulties (speech, gross motor, social, fine motor) results in improved community education, reduced later costs
- Improved school readiness of young children, allowing for improved community education
- Improved outcomes as a result of developmental and special education services reducing resource demand and improving community education
- Reduced costs associated with higher level developmental and special education services over time
- Improved school success (attendance, grades, behavior, completion) creates productive citizens

Child Welfare

- Reduced number of children in foster care placement
- Improved outcomes for families participating in preservation or reunification or kinship care
- Reduced re-reports and court cases

Mental Health

- Improved management of mental health symptoms and reduced acute mental health services
- Early identification and interventions for attention, conduct, and mood disorders among children resulting in reduced severity, crises, or acute mental health service needs
- Improved infant attachment resulting in reduced high-cost difficulties as teens/adults
- Intervention of mental health problems in other family members and subsequent improved symptom management and reduced acute mental health service needs

Substance Abuse Services

- Reduced relapse among women with substance use disorders (and thus reduced recidivism)
- Increased intervention, retention, and recovery in family members with substance use disorders
- Prevention of future substance use disorders in children

Improved Health, Capability, and Well-Being

- Improved family functioning and reduced family stress resulting in improved citizenship and contributions
- Improved parenting resulting in better brain development, social attachment, and development

IV. SERVICE DELIVERY MODELS

Family-Centered Treatment and Treatment Modalities

Family-centered treatment services can be provided in residential or outpatient-based settings. Service needs change throughout the duration of treatment. As families affected by substance use disorders progress, they typically require lower levels of care. Some organizations have developed a “recovery campus” that includes several residential programs for different populations, an outpatient-based program, a child development center, other community programs, and drug-free housing all on the same property. Other organizations move client families from more structured to less restrictive settings as they complete phases of the program. Clients move from residential treatment to day treatment combined with drug-free housing.

Family-centered services can provide individualized family services in the recovery campus, in a “full-service center,” or in a variety of community settings. Family-centered treatment programs can move families from higher levels of intensity to lower levels as the families stabilize and symptoms are reduced.

Specific interventions and services occur at each of four focus areas along a continuum of services including the following

- Prevention (universal, primary, secondary)
- Intervention (outreach, engagement, initiation of treatment)
- Treatment (see American Society of Addiction Medicine [ASAM] Levels of Service below)
- Recovery community support services (continuing care, relapse prevention)

The intensity of the structure of programs also varies. ASAM has established levels-of-care and placement criteria for different levels of individual addiction severity (American Society of Addiction Medicine, 2001). These placement criteria are based on individual need for substance use disorder treatment, not family treatment needs. Detoxification services can be delivered within each level of care. The ASAM patient placement criteria include three levels of outpatient care and four levels of residential care as follows

- Early Intervention
- Outpatient Services (includes ambulatory detoxification without extended onsite monitoring, outpatient treatment)
- Intensive Outpatient/Partial Hospitalization Services (includes ambulatory detoxification with extended onsite monitoring, intensive outpatient treatment, partial hospitalization treatment)
- Residential/Inpatient Services (includes clinically managed low-intensity residential treatment, clinically managed inpatient detoxification services, clinically managed medium-intensity residential treatment, clinically managed medium-/high-intensity residential treatment, medically monitored inpatient detoxification services, medically monitored intensive inpatient services [medically managed inpatient detoxification services, medically managed intensive inpatient treatment])

The principles of family treatment described earlier, combined with the ASAM placement criteria, give rise to the need for flexible, adaptable treatment options for families. Several factors must be considered in identifying the best method of service delivery for substance-involved families. These factors include

- Severity of substance use disorder and subsequent treatment requirements
- Severity of other co-occurring physical and mental disorders and subsequent treatment requirements
- Other life considerations in the family including employment, housing status, children's stability in schools
- Requirements and mandates from other systems (e.g., criminal or juvenile justice, child welfare, social services)
- Availability of individual and family resources as well as availability and access to various community treatment and supportive services

Residential Programs

Many women with substance use disorders require residential treatment to address their substance use and co-occurring problems. An ideal facility provides flexible configurations to accommodate families of all sizes. Family-friendly facilities are tobacco free, are free of environmental hazards, are suitable for children of different age levels, and have the capacity for children not living with their parent to visit overnight.

Residential facilities offer multiple benefits. For example, residential settings provide a supervised setting that allows for monitoring and safety provisions in families with a history of child abuse or neglect. Residential facilities offer the structure, meals, and safe housing that some children and adults affected by substance use disorders need. In residential facilities there are innumerable “teachable moments” to support family members as they build healthy relationships, make good decisions, and build healthy life skills. Unfortunately, residential treatment is the most costly and is out of reach for many families.

Most residential treatment facilities for families do not co-locate those partners who do not use substances in the residential program. Likewise, programs that accept partners who also have substance use disorders typically serve the adults in separate programs that may not be in physical proximity—for instance, the man is likely to enter a residential program for men, while the woman and children are located in a residential program for women with children. Some programs that serve whole families with residential services may offer family housing at a sober living-type facility and treatment services at a separate location.

Outpatient Family-Centered Treatment Services

Outpatient programs can also offer family-centered treatment. Appointments and groups can be scheduled so that multiple members of the family can be served at one time. Parenting classes, family counseling sessions, and the array of services needed by individual family members can be provided in an appropriately designed treatment center. When serving children as well as adults, the facility needs developmentally appropriate safe environments for children of different ages.

Many treatment centers have informal spaces (e.g., comfortable living rooms) for family and client–client interaction to build peer support, offer teachable moments, and help families feel more at home in the center. Other centers combine home visiting with outpatient services. Home visiting services can be used to engage participants, retain participation, educate and counsel families, and provide a safe environment to work with clients on life skills, parenting, and case management issues. In the substance use treatment continuum, home visiting can also be particularly useful as a recovery support or continuing care service once an individual has completed treatment or entered a lower level of treatment intensity.

Collaborations for Both Residential and Outpatient Clients

There are a number of different organizational models for the delivery of family-centered treatment. Some agencies deliver all the core services (clinical treatment, clinical support, and community support) themselves. They have established a multi-service center approach and employ staff members from the health, mental health, substance use disorder, vocational, child development, and family counseling fields. Other family-treatment models use a hub-and-spoke style of collaboration. Most of the services are provided at the primary service agency; however, the agency has collaborative ties with other service providers in the community to offer specifically identified components.

Most families entering treatment either are already involved in multiple service systems (e.g., child welfare) or qualify for services or benefits available in other service delivery systems (e.g., employment training), which makes collaboration both necessary and logical. The benefits of collaborating across delivery systems include

- Improved outcomes for families. By working together, agencies are able to eliminate conflicting requirements, identify workable plans, and maximize resources to help clients succeed. Services can be more client driven and less fragmented.
- Collaboration is cost effective. Collaboration leads to reduced duplication of services, maximizing funding through economies of scale and leveraging of resources to expand services.
- Increased early intervention opportunities across multiple service systems. Through cross-system training, each point of entry into services provides an opportunity for engagement, motivation, and screening for multiple service systems.
- Leveraging expertise and resources. By providing services using a collaborative, multidisciplinary team, each program is able to increase the expertise in the different service delivery systems. For example, a family violence agency can provide expertise on safety planning so that treatment programs do not need to have the expertise in house.
- Increased ability to meet concurrent and multiple needs, through flexibility and breadth of resources.

In providing family treatment, substance abuse treatment programs interface with other health and social service agencies including those described below. As previously discussed, cost-savings also occur across these systems.

- **Child Welfare.** The child welfare system provides for the safety, permanency, and well-being of children affected by child abuse or neglect. Estimates of between one-third and two-thirds of child welfare cases involve substance use (Department of Health and Human Services, 1999). Collaboration can result in the following
 - Ensuring timely access to services
 - Enhancing risk assessment
 - Increasing the availability, access, and appropriateness of substance abuse treatment for families
 - Promoting client retention and the effectiveness of services
 - Improving timelines and decision-making for children's custody

Collaborations provide expanded models of service delivery in family preservation, reunification, and kinship care. For example, one collaborative model facilitates early return of children to the same environment as their parents through a system of shared custody in which the treatment program holds physical custody of the children and supports the parents' care of the children.

- **Employment Programs.** Women with substance use disorders have low employment rates—lower than men with substance use disorders. Employment leads to improved esteem as well as economic well-being. For fathers, improving their economic or employment status is important because they have a perceived value of themselves as providers for their families. Individuals with substance use problems have multiple barriers to employment. Collaborations with job training programs, vocational rehabilitation programs, and job development programs allow programs to assist women and families toward economic improvements.
- **TANF, Food Stamps, and Crisis Support Programs.** Families with substance use disorders frequently need support to overcome obstacles related to poverty. Time limits on eligibility, increased employment resources, and mandates on participation call for collaboration. Establishing two-way relationships with TANF and other economic resources helps coordinate between program requirements and access innovative services (CSAT, 2002). In some communities, TANF resources may be used in a variety of ways to address family needs (e.g., rental subsidies, drug or alcohol treatment). In most communities, community services or human services departments and faith-based organizations also assist families with basic necessities such as food, shelter, clothing, and personal items.
- **Mental Health.** Forty-five percent of women with illicit drug dependence or abuse and 31 percent of women with alcohol dependence or abuse also had a serious co-occurring mental illness (Office of Applied Studies, 2004a). Integrated mental health and substance use treatment for co-occurring disorders has been identified as an evidence-based practice. Collaboration with mental health services can also result in early intervention in children's mental health needs.
- **Health.** Women with substance use disorders often have health needs requiring attention, including acute and chronic health problems, prenatal care, family planning services, and treatment for sexually transmitted diseases. Children require preventive health care, as

well as care for acute and chronic problems. Likewise, male partners and other family members often lack health insurance or access to medical care. Collaborations can assist programs in helping all family members meet their needs for dentistry, medications, and preventive health services as well as care for acute and chronic problems.

- **Family Violence.** Domestic violence and alcohol and drug use are highly correlated (CSAT, 2000). Family violence affects all members of the family. Children who witness violence may need specialized assessment and intervention services to address posttraumatic symptoms that may include behavioral, mental, or emotional problems and lack of safety. Early screening and assessment for family violence before establishing a family involvement plan facilitates safety planning, interventions for perpetrators, reports to authorities, and concurrent victim assistance services. Substance use treatment programs can collaborate for the delivery of counseling and skill-building services for clients as well as support to develop safety plans, identify “safe houses” when needed, assess perpetrator progress and sincerity, and support staff members in addressing client needs.
- **Criminal Justice.** The number of women in the criminal justice system has grown significantly in the last decade. Sixty-five percent of women in State prisons and 59 percent of women in Federal prisons in 1997 reported they had minor children. Sixty-five percent of women in State prisons also reported drug use in the month before their offenses. Ninety percent of fathers in State prisons reported that their children were currently in the care of their mothers, whereas 79 percent of mothers reported that their minor children were in the care of their grandparents or other family members (Mumola, 2000). Efforts to address the needs of incarcerated parents and their children, as well as treating substance use disorders among offenders, increase the potential for collaboration. Possible programmatic options include family drug courts, alternative sentencing, improved reentry to the community through engagement in a continuum of community-based treatment or continuing care services, interventions for children of incarcerated parents, and support for clients to meet parole or probation requirements.
- **Housing.** Approximately 34 percent of the homeless population is made up of families, often with a parent who abuses substances (Burt et al., 1999). Most families entering and completing treatment, in particular female-headed families, face challenges associated with poverty. Living in a safe alcohol- or drug-free environment improves outcomes for women and children. However, this environment can be unobtainable without special outreach to access the limited supply of rental subsidies, affordable housing options, and housing placement services for eligible clients. In addition to accessing housing in the community, some treatment programs are developing supportive housing, sober living, or service-enriched housing for clients and former clients, especially those with co-occurring mental health problems. Collaborating with housing and homeless service agencies can offer access to emergency and long-term housing needs for eligible families.
- **Child Development and Education.** Child development services increase school readiness, intercede in developmental lags, and provide a constructive, developmentally appropriate environment for children. Children in families with alcohol or drug involvement are often behind in school, experiencing academic failure, or exhibiting other special needs. By collaborating with child development centers, schools, and special education

services, programs can help women address their children's needs and increase the resources available to mitigate substance exposure.

Partnerships With Other Community Organizations

Numerous community organizations are responsible for serving low-income, high-need families. Many of these organizations do not provide services for parents with substance use disorders and their children even though these parents and children constitute one of their highest need populations. Families affected by substance use disorders often qualify but fail to access services in other service systems such as health, mental health, developmental services, education, or family resource centers. Through partnerships with other service organizations, family-centered treatment programs can provide an increased array of services to their clients while concurrently assisting other service providers in reaching the families who may be most in need but the most difficult to engage in family supports and community services.

V. CHALLENGES TO ESTABLISHING FAMILY-CENTERED TREATMENT PROGRAMS

Whereas the benefits of involving children and family members in treatment are clear, significant challenges must be overcome to provide family-centered treatment services. These challenges are both programmatic and administrative in nature.

Programmatic Challenges

Whom To Involve

Expert panelists at the CSAT Practice-Based Symposium on Comprehensive Family-Centered Treatment felt strongly that it should be the woman who determines how her family is defined and who should participate in treatment. The woman is at the core of the family. Potential participants may include children, spouses, domestic partners, children's fathers, siblings, parents, and other individuals who are important parts of the woman's life.

Families are dynamic, are unpredictable, and vary in size, needs, composition, and resources. The makeup of the client population changes as some clients leave and others enter programs. This can make staffing, space, and service planning challenging. Some expert panel members believed that it is easier to stabilize and provide structure for smaller families and families with younger children. Several of the initial RWC programs restricted the number and ages of children (CSAT, 2004). Particularly in programs where the parent and children have been previously separated, it can be beneficial for detoxification and stabilization to occur before the children and other family members come to the treatment site. Likewise, families of multiple members with multiple problems can be overwhelming for staff.

Adults

The purpose of family treatment is to rebuild the family unit so that the family can support the woman's recovery and thrive as a recovering family. Identification of family members may be a therapeutic exercise for the woman entering treatment. Programs may use tools such as genograms or relationship mapping to help women identify the status of their relationships. Because many women with substance use disorders have difficulty with boundaries and fear loneliness, they may easily identify a new sexual partner as a family member. In some instances, these individuals prove to be strong family assets; however, often they are not committed to the whole family's well-being. Regardless of whom a woman includes as part of her family, she may not decide that all of her identified family members should participate. Most programs have established minimum guidelines or requirements for involvement of adult family members. At a minimum they require family members to respect organizational policies to participate. They may offer or require engagement and outreach services, orientations, initial family groups, or assessment interviews before family members are able to participate. These requirements help ensure that participants are more likely to be helpful and less likely to be a hindrance to recovery.

Children

The makeup, composition, culture, strengths, and needs of each family are different. Family-centered treatment works to bring the whole family (as defined by the mother) together as a unit. Some families have one child; others have 10 children. In some families, the children have lived apart from the mother (and each other); in others they have stayed together. For large or high-need families, clinical treatment and support services can become a complex endeavor.

Sometimes older children are in need of intervention and treatment services for mental health, substance use, or other issues without which they are inappropriate members of the treatment community. This is particularly true with children who exhibit violent behaviors. Family-centered treatment programs set boundaries for conduct and establish a community culture that promotes a safe environment for all clients. When a child/youth cannot behave appropriately and disrupts the safe environment for others, including other children, the treatment team provides therapeutic services for the child and supports the mother in intervening and addressing the child's needs. If problem behavior persists, and the mother is working to address the problem, the family and treatment team identify ways to reestablish program safety for all clients. If necessary, the team may seek another setting or approach to support the family recovery process. When a child/youth requires a higher level of care or is so disruptive as to warrant placement in another setting, the program must identify an appropriate service setting and coordinate services with the adolescent program and the school system. If the youth enters foster care, or probation then the parent will likely need assistance to stay informed and participate in decisions affecting the child and plan for longer-term family needs. Programs are challenged to balance program safety and group needs, family needs, and individual treatment needs. Each family's need and ability to participate is evaluated on an individual basis—often, but not always, with a unique, optimal solution.

Some children do not want to be at the treatment program. This is particularly true of older children who do not want to part from their friends, may be comfortable where they currently reside, and feel angry with their parent(s). In some situations, the child who does not want to attend may be better off not coming to the program or participating in a more limited fashion. In others, it is more appropriate for the child to join his or her mother. These decisions, whenever possible, are made by the mother (and other adult family members), in consultation with the child, and with the support of treatment staff members who include the child's case manager.

Children Affect Treatment Dynamics

Programs that serve families must be flexible and adaptable. Each family and each member often has multiple appointments and therapeutic issues. Relationships between family members often need problem-solving support. Children of different client families experience relationships and conflicts, which often require mediation. These requirements are in addition to the traditional client-to-client issues that arise in treatment environments. Although these tensions offer opportunities for growth, support, learning, and developing life skills, they add to the set of skills needed at the program and use more time.

Staff must balance respect for maternal authority and empowerment of mothers with the importance of providing support and teaching them parenting skills. The requirement that all children are emotionally and physically safe and have their needs met can result in staff

members' becoming attached to children. These staff members may then experience frustration when they see the children's feelings get hurt, poor parenting, or poor outcomes.

Women must balance their care taking role and their need for self-care to achieve and maintain recovery. Programs need to be able to assess presenting issues, prioritize, and make allowances when appropriate, particularly during early stages of recovery when potential trauma triggers or other emotionally challenging circumstances increase relapse potential. Ensuring the safety and well-being of children while mothers stabilize may require innovative problem-solving. Many women with substance use disorders are emotionally immature, requiring a lot of personal attention from staff. It is not uncommon for a client to compete with her children for staff attention (CSAT, 2001).

Depending on how the family-centered treatment agency is structured, the program retains a commitment to serving each individual member of the family based on each individual's treatment plan, regardless of whether the woman discontinues participation. When programs are able to offer therapeutic services for children related to a mother's return to drug use, it can help children cope with abandonment. The treatment provider may also work with the family to maintain a strong network of support for children and one another. The provider may need to help the mother develop linkages and ensure that services are continued through the local children's mental health system or that the child has opportunities to engage in other forms of youth development activities. These services may occur formally through ongoing service contracts or informally through collaboration with child welfare and other service agencies.

How and When To Involve Family Members

Preparing families to participate

Although an occasional family may enter treatment together with all members ready to participate, more often the reestablishment of the family and the delivery of family-centered treatment is a process. There may be some family members, whom the woman wants to have participate, who no longer want to be a part of her "mobile." A woman's substance use hurts family members who care about her. These family members may feel anger, abandonment, and distrust to the point that they do not want to participate in her recovery effort. With time and demonstrations of responsibility and caring, these family members may develop faith in the woman's recovery attempt and initiate participation.

Often intensive outreach and engagement services are needed to involve family members in the treatment program (McMurtrie, 1999; Price & Simmel, 2002). In one study of men whose partners were in treatment, more than 90 percent saw the women's substance use disorders as a stigma to the woman and to themselves (Laudet et al., 1999); this view makes men resistant to participating in treatment. In addition, many women entering treatment have current relationships that not only can discourage the women from entering treatment, but also support their continued drug use, provide drugs, and encourage relapse (Brady & Ashley, 2005; McCollum et al., 2005; Price & Simmel, 2002). Programs may encourage women to begin their recovery process and establish a foundation of treatment before deciding whether they want their partners to participate. Outreach and engagement services, combined with collaboration with other service systems in which family members are engaged, can help these family members address their own issues. With time, these individuals may be motivated to address their own substance use and mental disorders. In families where both parents have substance

use disorders, the family may receive treatment together or the partners may enter separate treatment programs. When partners enter separate treatment programs, the preference is usually for the children to stay with the mother. Collaboration and case coordination between treatment providers serving the different partners will optimize the ability of the family members to address their individual needs and facilitate joint services and family decision-making.

Programs must balance family need with a healthy allocation of resources. Sometimes a family's resistance to participation or its level of need is so great that serving it detracts from the overall ability to serve others. Although services remain individualized and flexible, the program must always balance an individual client's needs with a commitment to the overall health and safety of the program environment.

Trauma and Violence

In a family with a history of violence, ensuring the safety of the woman as well as other program participants and staff members is paramount. Family-centered treatment providers work closely with a woman to determine whether and when it is appropriate for a partner or family member with a history of violence to become involved. The provider may support the woman's decision to involve her partner by developing a safety plan and ensuring that both partners receive the appropriate services. Should the woman or treatment provider determine that the relationship does not facilitate the woman's recovery and safety, program supports should be in place to ensure a safe transition that allows both individuals to continue individualized services but not as a family unit.

Maintenance of a trauma-informed environment and trauma and crisis services are crucial features of a family-centered treatment program. Most women with substance use disorders have experienced physical, sexual, verbal, or emotional abuse as children. Involvement of their own children, other family members, or perpetrators of past abuse can trigger trauma reactions that are not conducive to recovery. Some women may desire that a sibling, parent, or other caretaker engage in treatment with them and later find that the other person's involvement is not conducive to recovery. Families are dynamic and changing. In these instances, programs must be able to support disengagement and individualized services for all family members involved.

When reunification is not the best option

Reunification of the family may not be the best option when a woman cannot stabilize in her recovery (substance use and severe mental health problems), a child has a strong attachment to another caregiver, or the mother has not developed a strong attachment to the child. Whatever the reason, sometimes a treatment program must assist a mother in establishing an alternative relationship between herself and her child. For example, a program may support a woman to accept another family member's raising the child while the mother remains in contact and is supportive (to the best of her ability) of the child. Programs can help transition this family view toward acceptance and celebration of the family network. Supporting a mother in releasing custody of her child and staying drug-free is clinically challenging. It can also challenge the sense of safety of other clients in the facility; other clients may blame program staff and fear similar consequences. Clear communication and ongoing dialog with participants can help offset any disruptions to the program environment.

Other considerations in family treatment

Family treatment is a dynamic process with individuals at different stages of intervention, assessment, case management, and service delivery for their substance use, health, mental health, developmental, and other needs. Family case coordination helps keep individual service plans in line with the overall family goal and objectives. As treatment progresses, counseling, community support services, and family decision-making conferences or workshops allow the family unit to work together to resolve conflicts, improve relationships, meet treatment goals, and enhance its well-being. Having a positive support network greatly increases a family's treatment retention as well as in reduction in substance use. As families grow stronger, parenting improves, and communication is established; all members can thrive.

Administrative Challenges

Staffing

The right combination of qualified and supported staff is the basis for quality service delivery. Family-centered treatment requires a multidisciplinary team of staff members who are able to work together to help families rebuild their lives (CSAT, 2001, 2005; Price & Simmel, 2002). Service delivery for family-centered treatment typically combines direct program staff, contract staff, and linkages with other service organizations. The specific staffing pattern depends on the treatment modality, base agency, established collaborations and linkages, and client population. From the board of directors, to management, to clinical and treatment staff, the organization should reflect the diversity of the client population and incorporate gender and culturally competent policies and practices. Cultural competence can be more complex in a family model with different cultures, levels of acculturation, and values in individual families.

Offering comprehensive family-centered treatment involves the establishment of a multidisciplinary staff. Programs may need to recruit staff members (or collaborations) to offer the wide range of services that women and their families require.. This staff should include individuals who are culturally responsive and equipped with skills necessary to work with children, teens, adults, and family networks. Mechanisms must be put in place to ensure that all staff members can meet, communicate, and work together on a regular basis. When significant services are provided through linkages, it typically involves identifying a dedicated staff member from each organization; holding collaborative meetings; building a shared vision, goals, and a work plan; and maintaining a culture that supports unity and prevents service fragmentation.

Often because of budget constraints, programs must balance the demands of licensing requirements (particularly for child care) and professional staff with the need for low staff–client ratios, supervision, time for training and consultation, and night and weekend coverage. Most programs must establish the staffing pattern in the context of billable services. This consideration often limits the time available for critical functions such as training, supervision, case conferencing, and collaboration. Because there is not a specific family services funding stream, most agencies combine or braid different sources to develop a comprehensive package of services and supports to meet as many of the family needs as possible. This process adds a significant burden to the administrative functions of the agency. There is a constant need to seek out funding sources, to educate potential funders about the family treatment concept, to

write grant applications, to qualify the agency for contracts, and to provide multiple evaluations and outcome information that meet the specific needs of each the various funding interests.

Expert panelists in the Comprehensive Family-Centered Treatment Symposium agreed that in addition to the necessary professional qualifications, staff members need other essential characteristics. These personal and professional qualities also create a supportive and relevant agency culture that supports families. These qualities include

- The ability to relate at a human level and have genuine care and concern
- The belief in and commitment to the treatment philosophy
- The ability to be flexible and adaptable
- The ability to respond to multiple and changing client needs
- Having a personal interest in learning and professional development
- Having a team and collaborative orientation: respecting other professions' values, expertise, and opinions
- Being aware of their clients' and their own strengths, biases, and limitations
- Respecting and appreciating cultural diversity among both staff and clients

Family-centered treatment requires a significant investment in staff training and supervision. Training fosters an understanding of family-centered treatment models, philosophy, and approach as well as of agency policies and procedures. Cross-training builds respect, understanding, and collaboration among the different disciplines working in the family-centered treatment program. Communication, decision-making, and cross-training all contribute to reduced tension among staff members. Supervision provides a structure to reduce stress and anxiety, creates an atmosphere of problem-solving and learning, and reinforces the organizational values and clinical practices in family-based treatment. Regular supervision provides staff members with an objective perspective on constructive ways to approach difficult situations with clients; helps employees feel that they are part of a group; and facilitates regular feedback, growth opportunities, and a structure for ongoing communication.

Because family-centered treatment is a highly personal and cultural experience, it is important that program staff members have the opportunity to examine their own biases, identify their strengths and weaknesses, identify their boundaries and competencies, and build a base of cross-collaboration. Some issues that may create problems and tensions for staff include concerns about how clients treat their children, especially if a parent uses corporal punishment; women who choose to stay with male partners who have a history of violence; and nontraditional relationships. In addition to receiving training, staff members need adequate time to process training content, incorporate new knowledge with existing knowledge, apply new skills, and reflect on their attitudes. Several programs hold weekly training or debriefing sessions for staff.

In the substance use disorder treatment field there are shortages in the workforce. These shortages are magnified when programs seek staff members who also have experience and competence in working with children and diverse populations. Low salaries combined with challenging clients, long hours, and multiple demands create high staff turnover. Experts at the symposium commented that treatment programs serve as a training ground for interns; as soon as the interns gain experience and master counseling approaches and interventions, they often leave for jobs with higher salaries.

Collaboration

Working with other service delivery systems provides significant opportunities for family treatment programs to address the complex needs of families with substance use disorders. However, there are significant barriers to developing effective collaborations. Challenges in working with other systems can be grouped into four key areas

1. Lack of leadership and a structure on which to base coordinated efforts. Often there is mistrust and poor communication between agencies. At both the systemic and individual practitioner levels, agencies must reach agreement on common values, philosophies, language, and purpose.
2. Operational barriers to integrating systems. Operational barriers include different, incompatible systems and an inability to share information across agencies as well as mandates and funding restrictions that discourage collaboration.
3. Often staff members are not adequately trained to understand the value of other service systems' contributions or the constraints placed on their services.
4. Limited resources. Providers of all types often face serious constraints regarding the number of individuals and families they can serve and the range and intensity of services they can provide because of financial and human resource limitations.

Collaboration does not just “happen” but requires an investment of time, training, and active planning and transition to surmount these hurdles.

Funding Challenges

Families under stress face tremendous challenges in their ability to function as healthy family units. Poverty, domestic violence, child abuse, substance abuse, divorce, and emotional stress all place extraordinary pressures on the family and threaten its ability to stay together to meet the needs of each of its members. It is difficult to provide or access through community channels the full array of health, mental health, developmental, educational, vocational, and supportive services that a family needs.

Specific funding criteria may prevent access to necessary services. For example, women experiencing trauma often require mental health services but may not meet the “medical necessity” threshold that deems them eligible for Medicaid-funded mental health services. For children to be able to receive developmental intervention services, they too must meet a threshold of need. These are real challenges to treatment providers trying to address the full range of family service needs.

There are also shortages of clinical treatment, clinical support, and community support services available for people with low incomes. Available services are often geographically or culturally challenging for clients. When appropriate services are not available, the program must identify alternative ways of delivering the necessary services.

Funding of family-centered treatment must be at a sufficient level to meet the salary needs of a qualified, diverse, and professional staff team. The substance use disorder treatment field has been struggling with a workforce crisis. Maintaining a qualified, diverse workforce within the

budgeted salaries is a problem across the service delivery system. Stigma, under funding, credentialing requirements, and a lack of public support all handicap the field's ability to establish, maintain, and retain a qualified workforce. Treatment providers have referred to themselves as "training grounds" where new professionals come, learn to become effective clinicians and counselors and then leave for better opportunities. To maximize positive outcomes, family-centered treatment must be able to overcome the staff-salary obstacles.

In most communities across the United States, gaps exist in the availability of services. In treating whole families, organizations are challenged to establish the linkages or other service mechanisms to provide the health, mental health, and substance use treatment; parenting; and other services that family members need. Experts at the symposium strongly believed that development of family-centered treatment services should not divert resources away from women's treatment and that new funds should be identified to meet the array of family member service needs. Categorical funding can pose challenges to delivery of family-centered treatment. Inflexibility of many funding streams prevents the delivery of services customized for the specific needs of individual families. Organizations providing family-centered treatment typically have multiple funding sources to meet the more common needs of clients. Yet these funds are often time limited and restricted to specific service provisions. Organizations find that they have funding for X but they have a client who needs Y. They then have a choice of providing the client with X (because this will provide some help) or persisting in identifying unrestricted revenues so that they can provide the client with Y. As funding agencies move toward funding programs for outcomes (client improvement) rather than inputs (services provided), family-treatment programs will be better equipped to offer optimal service delivery, customized to meet the needs of individual families. The companion paper to this document, *Funding Family-Centered Treatment for Women With Substance Use Disorders* provides a discussion of available funding for family treatment and components of family treatment.

Facilities

Most family-treatment agencies do not have the financial resources to design and build model treatment facilities. Experts at the symposium cited the lack of funding for facility improvement or expansion and requirements for expedited program startup as barriers to establishing quality facilities. Time constraints, combined with NIMBY (not in my backyard) challenges to local use permit processes, often prevent programs from designing and constructing facilities. Programs instead rely on converting existing buildings into family-treatment facilities. Residential facilities have previously served as motels, apartment buildings, group homes, or hospitals. Outpatient facilities are often developed in converted medical offices, retail establishments, or warehouses.

Regardless of the modality of services, clients benefit from feeling a sense of safety and security in a welcoming program environment. Programs need to offer both a sense of safety and accessibility. Clients need to feel safe getting to and entering the facility. To feel safe, clients must be able to access the program without fear of violence, feel certain that their confidentiality will not be compromised, and sense they are respected and accepted. Because many clients rely on public transportation, they must be able to access the program facility with relative ease while meeting other family responsibilities.

Facilities may need to be designed so that family members, other service providers, and visitors can come and go from one area without disrupting the primary treatment environment. This

protects clients from possible trauma triggers, confidentiality breaches, and violation of the sanctity of the treatment community. Onsite child development services should require developmentally appropriate outdoor and indoor play spaces, separate bathrooms, and a clean environment.

There are benefits to offering family treatment in residential settings; however, locating appropriate facilities can be extremely difficult. Some States have special licensing or fire clearance requirements for facilities serving families with children. For residential programs, the ideal facility has a flexible construction to accommodate families of different sizes; soundproof walls that allow one family to sleep while the infant next door cries, and several living rooms that enable families to congregate together.

Facility maintenance can also be challenging for substance use treatment providers. Negotiated leases often require the program to absorb the cost of any maintenance and repairs. Especially in older buildings, ongoing maintenance and facility management costs are high, and unexpected repairs can be crippling for small, service-minded, nonprofit organizations.

Measuring Outcomes

Although families are considered the central unit of society, the health and social service delivery systems, including those for alcohol and drug treatment, have been designed for individuals. Across the country, the mechanisms for client identification and placement, funding, and evaluation are based on the needs of individuals with substance use disorders. Organizing and aggregating data by individual and familial relationship can be extremely complex. A wide range of indicators and measures can be used to establish individual, relational and system outcomes. Evaluation tools and data systems are currently oriented to address one specific diagnostic area of one specific client. State implementation of the National Outcome Measures will shape reportable outcomes. Effectively tracking outcomes for family members requires adjustments to the current information systems that are designed to track individuals rather than families.

Cost–benefit analysis and systems evaluation can produce an analysis of the possible benefits of a nationwide effort to address the intergenerational cycle of substance use. There can be little doubt that providing family-centered treatment offers society more benefits and cost savings over time than it costs to implement. Table 2 identified service systems and cost savings that could be realized in these systems. Using cost savings to gain the necessary support for implementing family-centered treatment remains a challenge. One of the difficulties in initiating family-centered treatment is that the costs are incurred in service delivery systems different from those in which savings are realized. Furthermore, and perhaps more significant, the cost to implement family treatment is a real-time cost but many of the “savings” occur in the future (some are short-term and some are long-term). This is a universal issue for programs or activities that prevent the incurrence of future costs. Another challenge is to identify the savings as savings. The realized savings come in the form of “cost omissions” for expenses that would have occurred without the family treatment. There is no line item that reminds service systems of the costs that would have occurred if they had not been prevented. The challenge is to identify methods that allow for cost sharing and reallocation of resources based on future savings in the implementation of family-treatment approaches.

VI. CONCLUSION

Each decade has moved us closer to meeting the needs of women and families with substance use disorders. The 1970s gave birth to women's treatment programs; the 1980s expanded research on women's substance use. In the 1990s programs serving pregnant and parenting women emerged. The current decade has responded to growing knowledge through the development of gender-responsive services that meet the needs of women. Concurrently other service systems have recognized the effects of substance use disorders, making collaborations and innovative service delivery methods more possible. The stage is set for further progress in meeting the complex needs of substance-involved families. Family-centered treatment offers the possibility for family and community transformation, creating a synergy in outcomes so that improvements in one family member lead to improvements in others.

The effective delivery of family-centered treatment will require dedicated treatment providers to access adequate funding across systems, hire appropriate staff members, provide ongoing training, secure adequate facilities, and establish effective collaborations. Family-centered treatment programs that maintain flexible, individualized services while offering safe and supportive environments are best suited to draw on the range of community services needed to engage and support family recovery.

Supreme Court Justice Sandra Day O'Connor said, "We don't accomplish anything in this world alone . . . and whatever happens is the result of the whole tapestry of one's life and all the weavings of individual threads from one to another that creates something." We are reminded of this saying as the substance abuse treatment field is challenged to more comprehensively address the full range of family needs and reaches out to other community supports to combine their contributions into comprehensive services that promote family well-being.

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ATTACHMENTS

- Attachment 1:** **Additional Data on the Extent of the Problem**
- Attachment 2:** **Symposium Participants**
- Attachment 3:** **CSAT's Comprehensive Substance Abuse Treatment
Model for Women and Their Children**

Attachment 1. Additional Data on the Extent of the Problem

Characteristics of Women and Families With High-Risk Use

In 2002 and 2003, 4.3 percent of pregnant women ages 15 to 44 used illicit drugs, and 4.1 percent reported binge alcohol use. During the first year after giving birth, 8.5 percent of mothers reported use of an illicit drug, and 14.9 percent reported binge drinking during the last month (Office of Applied Studies, 2005c).

SAMHSA's Office of Applied Studies (OAS) (2004c) looked at substance use and marital and parental status for women ages 21 to 49 (Table 1). It found that 73

percent of married

women, 63 percent of

divorced or separated women, 44 percent of women living with a domestic partner, and 27 percent of single women have children younger than age 18 living with them. Rates of substance use (binge alcohol use or any illicit drug use) were higher for women living with an unmarried partner across all age groups. Rates of past month substance use are lower for married women than for non-married women ages 21 to 49. Of the 73 percent of married women with at least one child living at home, an estimated 14.5 percent reported past month binge alcohol use, and 4.0 percent reported any illicit drug use. (Note that the percentage of married women without children reporting substance use is higher than the percentage of married women with children in the home: 16.6 percent report binge alcohol use, and 6.2 percent report any illicit drug use.)

In 2002, OAS estimated that 5 million of the 69 million adults living with at least one child younger than 18 were alcohol dependent or alcohol abusing. Of these, 69 percent were married, 62 percent were fathers, and 38 percent were mothers. OAS estimated that 35.5 percent of these individuals also experienced illicit drug use and 11 percent of those without alcohol dependence used illicit drugs (Office of Applied Studies, 2004b).

Table 1: Women's Past Month Substance Use by Marital Status, 2002			
	% With Binge Alcohol Use	% With Any Illicit Drug Use	% With a Child Younger Than 18
Married women ages 21–49			73
Ages 21–25	19.3	7.2	
Ages 26–34	14.6	5.0	
Ages 35–49	14.7	4.1	
Women ages 21–49 who are divorced or separated			63
Ages 21–25	27.3	14.8	
Ages 26–34	28.3	9.5	
Ages 35–49	21.2	9.2	
Women ages 21–49 living with an unmarried partner			44
Ages 21–25	34.8	21.4	
Ages 26–34	27.0	9.6	
Ages 35–49	29.3	13.3	
Women ages 21–49 never married			27
Ages 21–25	40.1	17.5	
Ages 26–34	27.0	9.6	
Ages 35–49	20.5	6.8	

Source: Office of Applied Studies, 2004c.

OAS indicated that 6 million (9%) of the nearly 70 million children younger than 18 in the United States lived with at least one parent who was dependent on alcohol or an illicit drug during the past year. Of these children, more than two-thirds lived with a parent who was alcohol dependent (Office of Applied Studies, 2003). Among families with a member who was alcohol dependent, household turbulence was significantly more likely than in other families. In households with persons who were alcohol dependent, 40.4 percent reported that people often insult or yell at each other compared with 27.3 percent in households with no past year alcohol dependence or abuse. Likewise, 29.8 percent indicated that people in the household have serious arguments in households with an alcohol dependence or abuse versus 18.2 percent in households without alcohol dependence or abuse. In households with alcohol dependence or abuse 11.8 percent of the spouses or partners hit or threaten to hit one or more times, and 9.9 percent of the respondents hit or threatened to hit their spouses or partners one or more times in comparison with 4.6 percent and 3.6 percent respectively in non-alcohol-dependence or -abuse households (Office of Applied Studies, 2004b).

Maternal substance use increases the likelihood that a youth will use alcohol or illicit drugs. Children of parents who have used marijuana are three times more likely to have used marijuana than children whose parents have not used marijuana (Kandell et al., 2001). Data from 2002 and 2003 indicate that of mothers living with a biological, step, adoptive, or foster child ages 12 to 17, 8.7 percent had a serious mental disorder only; 16.1 percent had a substance use disorder (illicit drug use, binge drinking, or heavy alcohol use in the past month) only; and 3.2 percent had both a serious mental and a substance use disorder. Youths living with a mother with a serious mental illness had an increased risk of past month alcohol or illicit drug use (26.7%) compared with youths living with a mother who did not have a serious mental illness (18.8%). The odds of substance use increased by 93 percent when a youth's mother used substances (Office of Applied Studies, 2005a).

Table 2: Selected Intake Characteristics of Men and Women in the ADSS			
	Total	Female	Male
Total Surveyed	4,520	1,137	3,383
Not married	74.2%	76.8%	73.3%
Married/common law	22.4%	19.4%	23.4%
Unknown/not mentioned	3.5%	3.8%	3.3%
Total	100.0%	100.0%	100.0%
Have Children at Admission			
Yes	54.6%	70.1%	49.5%
No	30.7%	21.3%	33.8%
Unknown/not mentioned	14.7%	8.6%	16.7%
Total	100.0%	100.0%	100.0%
Living Arrangements at Admission			
With spouse/partner	24.8%	25.2%	24.7%
With parents	21.3%	17.7%	22.4%
Alone	11.2%	10.7%	11.3%
With other family	9.0%	11.3%	8.2%
With children only	2.7%	8.2%	0.9%
No stable arrangement	7.7%	7.4%	7.8%
With friends	5.5%	4.7%	5.7%
Correctional institution	2.7%	0.9%	3.3%
Other institution	2.9%	2.6%	3.0%
Unknown	12.2%	11.4%	12.5%
Total	100.0%	100.0%	100.0%

Source: Brady & Ashley, 2005.

Characteristics of Women and Families in Treatment

The Alcohol and Drug Services Study (ADSS) (Brady & Ashley, 2005) consisted of three phases of data collection. Phase 1 was a survey of 2,395 treatment facilities. Phase 2 looked at client discharge data from 62 nonhospital residential and outpatient programs between 1997 and 1999. The Phase 2 data provide information about women and men participating in treatment programs as shown in Table 2. According to the Phase 2 data, fewer than 20 percent of female participants are married. Seventy percent of the female participants have children with them. This study also asks where clients are living at the beginning of treatment. Twenty-five percent of female clients reported living with a spouse or partner, and 29 percent lived with either their parents or other family members. Eight percent of women reported living with only their children and no other adults.

These rates correspond with those found in a recent study conducted of individuals who were opioid dependent presenting for methadone maintenance in Connecticut (McMahon et al., 2005) that examined parenting and marital status of men and women (n=524). Twenty-six percent of women and 20 percent of men reported being currently married. Eighty-one percent of women, compared with only 55 percent of men, reported being biological parents. Forty-one percent of men who reported having biological children resided with a biological child. (This is 11% of the total male client sample.) Forty-five percent of women with biological children reported living with a child (37% of the total female client sample). A total of 100 of the 524 clients lived with a biological child (60 mothers and 40 fathers). Men represent a greater percentage of individuals seeking treatment; however, a greater percentage of the women seeking treatment have children.

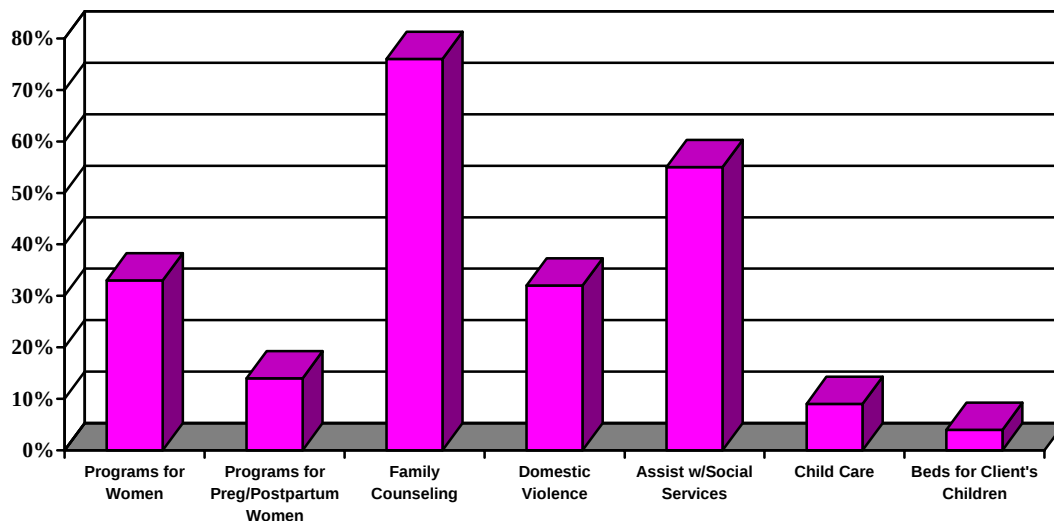
Conners and colleagues (2004) reviewed data collected by SAMHSA for the RWC/PPW programs funded between 1993 and 2000. This research shows the importance of engaging families in services. Approximately one-third of these women lived with a spouse or partner in the year before entering treatment. Of these, 44.5 percent reported that their partners used alcohol, and 57.5 percent reported illicit drug use by their partners. More than three-fourths of women reported that their families were involved in alcohol- or drug-related activities. Almost half the women (42.9%) reported having fewer than two friends who did not use drugs. Only 50 percent of the children reported having a friendly, adequate, or close relationship with their fathers. More than half the women participating in the RWC/PPW programs reported a history of abuse by their parents, and three-fourths had experienced abuse by someone other than a parent. They also reported on alcohol or drug use of their parents. For children living with grandparents, rates are also high for drug use (23.1% of grandfathers and 7.9% of grandmothers) and alcohol use (32.4% of grandmothers and 54% of grandfathers).

Availability of Family-Centered Treatment Services

The 2005 National Survey of Substance Abuse Treatment Services (N-SSATS) provides information on programs and services offered by 13,371 public and private treatment facilities throughout the United States and its jurisdictions. In 2005, 33 percent of facilities reported that they offered special programs or groups for women, and 14 percent offered programs for pregnant or postpartum women (table 3). Four percent of women entering treatment in 2005 were pregnant. Furthermore, more than three-fourths (76 percent) of treatment programs

reported offering family counseling; however, facilities with women-specific programs were more likely to provide family counseling than those without women's programs (82 vs. 75 percent) (Office of Applied Studies, 2006). Family counseling is undefined and may refer to highly limited services such as occasional education groups or an individual session that is part of discharge. These limitations make it difficult to use this category to measure family-centered treatment services.

Table 3: Substance Use Disorder Programs and Services: 2005
Percentage of Treatment Facilities Offering Given Service



Source: Office of Applied Studies, Substance Abuse and Mental Health Services Administration (2006). National Survey of Substance Abuse Treatment Services (N-SSATS) Profile: United States 2005. Rockville, MD: author.

In regard to other types of services important to comprehensive family-centered treatment, 9 percent of all facilities offer child care, 32 percent provide domestic violence (family or partner violence) services, 55 percent provide assistance with obtaining other needed social services and 4 percent provide residential beds for client's children (Table 3). Again, facilities that provide women-specific programs or groups, when compared with those that do not, are more likely to offer these types of family-centered services.

Attachment 2. Symposium Participants

A Practice-Based Symposium on Comprehensive Family-Centered Treatment

Sponsored by
Substance Abuse and Mental Health Services Administration (SAMHSA)
Center for Substance Abuse Treatment (CSAT)
In conjunction with the Rebecca Project for Human Rights

Washington, DC
July 21–22, 2005

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Attachment 3. CSAT's Comprehensive Substance Abuse Treatment Model for Women and Their Children

CSAT Women, Youth and Families Task Force
Center for Substance Abuse Treatment
Substance Abuse and Mental Health Services Administration
U.S. Department of Health and Human Services

revised 2004

Background

In the early 1990s, Congress appropriated funds to the newly created Substance Abuse and Mental Health Services Administration (SAMHSA), Center for Substance Abuse Treatment (CSAT), to support long-term residential substance abuse treatment programs for women with children. Two demonstration programs were funded, including the Residential Women and Children (RWC) program and the Pregnant and Postpartum Women (PPW) program. Based in part on the experiences of the RWC and PPW programs, CSAT developed the Comprehensive Treatment Model for Alcohol and Other Drug-Abusing Women and Their Children to help substance abuse treatment providers develop program services to meet the comprehensive needs of the women and children served by these and other programs. The Comprehensive Treatment Model was included in a 1994 CSAT publication, *Practical Approaches in the Treatment of Women Who Abuse Alcohol and Other Drugs* (Center for Substance Abuse Treatment 1994a).

This model recognized that there was an important difference between “treatment that addresses alcohol and other drug abuse only” and “treatment that addresses the full range of women’s needs.” As stated in the model,

Treatment that addresses the full range of a woman’s needs is associated with increasing abstinence and improvement in other measures of recovery, including parenting skills and overall emotional health. Treatment that addresses alcohol and other drug abuse only may well fail and contribute to a higher potential for relapse. (Center for Substance Abuse Treatment 1994a, p. 267)

CSAT’s model remains an important contribution toward describing an approach to working with women that recognizes the importance of gender in the design and delivery of services for women and their families.

Since 1994, the substance abuse treatment field has gained additional insights into critical needs of women and children and the role that partners and fathers play. The knowledge acquired in the past decade should drive the delivery of services to women. This information includes the following:

- Psychological differences between men and women and, in particular, the heightened importance that women place on relationships, have a great influence on women’s gateways into addiction and into relapse once the woman is in recovery. A woman’s focus within relationships is often to serve as caretaker, a role that can result in a woman’s not attending to her own needs. Positive, therapeutic relationships, on the other hand, also can act as powerful tools for supporting a woman’s recovery.
- Women self-medicate with addictive substances to mask pain associated with underlying trauma, including past and ongoing domestic violence as well as childhood abuse and neglect. The high prevalence of a history of trauma among women receiving substance

abuse treatment heightens the need for substance abuse treatment providers to recognize the critical effect of trauma on women's recovery.

- The prevalence of co-occurring mental disorders among women receiving substance abuse treatment also has come to light over the past decade and identifies the need for providing coordinated services to address both substance use and mental disorders.
- Women appear to be significantly affected by the service systems they depend on, including welfare agencies and child welfare agencies, which tend to operate independently, with different timetables and perspectives on the purposes of recovery.
- A new understanding has arisen about the benefits of women's economic self-sufficiency in the process of long-term recovery. This understanding is partly a result of the pressures of society, exemplified by welfare reform and data indicating that gainful employment can be a protective influence on preventing relapse.
- The substance abuse treatment field also now appreciates that children of women in treatment have many of their own needs that cannot be addressed simply by the provision of child care and residential living space. These needs are addressed when children are provided services directly, as well as when the needs of children's parents are met.
- Both mothers and fathers should receive the education and support necessary to prepare them for the responsibility of parenthood. This preparation must be undertaken with an understanding that the roles fathers play in families are diverse and are related to cultural and community norms. A father's role may also be related to his own health and well-being as well as the viability of the parents' relationship to one another.
- Changes in family composition play a role in supporting women and recovery. In 1960, there were just over 0.5 million single working mothers. By the mid-1990s, the number had grown to 2.1 million, with nearly 25 million children not living with their fathers by the turn of the century (U.S. Bureau of Labor Statistics 2003). More than one-third of these children do not see their fathers at all during the course of a year. Studies show that children who grow up without responsible fathers are significantly more likely to experience poverty, perform poorly in school, engage in criminal activity, and abuse drugs and alcohol than children with responsible fathers (U.S. Department of Health and Human Services 2000).

This draft updates to the Comprehensive Treatment Model from 1994 based on the knowledge gained over the past decade and responds to the new understandings about women, their children, and their families in the context of their communities and cultures.

An Evolving Paradigm

As was the case with the earlier version, the purpose of this update of the model is to

foster the development of state-of-the-art recovery for women with alcohol and other drug dependence and to foster the healthy development of the children of substance abusing women. The model is a guide that can be adapted by communities and used to build comprehensive programs over time. (Center for Substance Abuse Treatment 1994a, p. 267)

CSAT's Comprehensive Treatment Model continues to reinforce that confidentiality and informed consent, as well as the establishment of universal precautions against the spread of sexually transmitted and other infectious diseases, are essential throughout all aspects of treatment (Center for Substance Abuse Treatment 1994b, 1996, 1999, 2000; Winters and Zenilman 1994).

In addition to incorporating the new knowledge about the common histories and service needs of women and their children, this model goes a step further by delineating the relational elements of the service continuum that have an effect on treatment for women. These elements are shown in figure 1 below and are categorized as

- **Clinical treatment services for women.** Services necessary to address the medical and biopsychosocial issues of addiction.
- **Clinical support services for women.** Services from treatment and services providers to assist clients in maintaining their recovery.
- **Community support services for women, children, and their families.** Services and community resources outside treatment but within a community that are an underpinning or support system for the recovering individual and family.

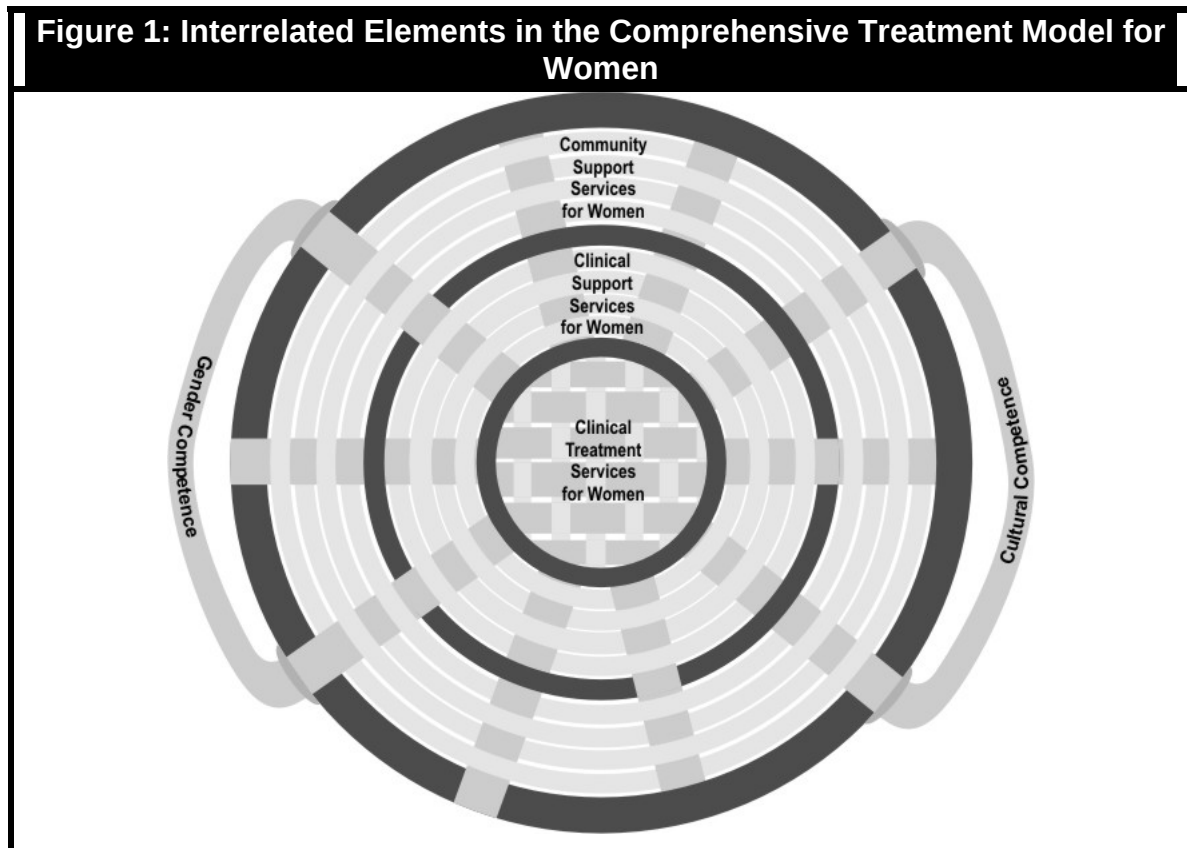
In parallel to these services for women, the model also describes clinical treatment and clinical support services to meet the needs of the children of women in treatment.

Research has established that there are many paths to recovery from alcohol and drug problems. Some women resolve their alcohol and drug problems with individual and family supports and without any outside intervention. Others recover with support from mutual-help groups such as Alcoholics Anonymous or the faith community. Still others have found recovery through formal treatment interventions. A variety of factors can influence which of these paths is successful, including the severity of the problems and the support systems available to women with substance use disorders.

To achieve the best outcomes at the lowest cost, SAMHSA encourages the establishment of a comprehensive continuum of recovery. The full complement of these services is appropriate for many women who meet the *Diagnostic and Statistical Manual of Mental Disorders* (American Psychiatric Association 1994) diagnostic criteria for substance use disorders. However, not all services or interventions are needed by every woman in treatment or recovery for substance dependence, and women who meet the diagnostic criteria for substance abuse may require a less comprehensive range of services than those who are substance dependent. Similarly, women with a range of family, social, and economic supports may not require a full complement of services, whereas those who have fewer naturally occurring supports may require more services from the formal health, social, and economic support systems.

The array of services described below need not be provided by a single entity but in most instances will be provided by a consortium of addiction treatment, health, and human services providers. The continuum is not specific to philosophies of treatment and recovery, modality, or setting. It is a generic framework within which providers can conceptualize service arrays, service capabilities, and appropriate managerial and administrative processes.

Methods of implementing the elements, staff members who deliver each service, the manner and setting in which different services are delivered, and other elements of the model should be based on an assessment and a patient placement determination that considers (1) the needs of the individual and (2) the extent to which the continuum of services is available in the community.



To understand the model better, a person should view services as a series of interwoven and interdependent circles of care that are necessary to support the recovery process for women.

In the Navajo Nation, the woven basket is actually a series of concentric rings, one lying within the other, expanding outward and upward until the entire basket is shaped. By itself, one ring can hold nothing and bear no load. When bound together, the circles join and gain strength, and what before could hold nothing now holds stones for building nations and water for building bodies.

The concept of interdependence is critical to understanding the Comprehensive Treatment Model. Each circle requires the existence of the other two, yet their boundaries must be flexible. The three circles together constitute comprehensive treatment, and any provider seeking to use the model must ensure that there is an interdependent relationship among the three systems.

Borrowing from the basket metaphor, the circles are also three dimensional as a basket must be and, as such, have binders that interweave and hold the circles together. Likewise, in treatment, there are activities that interweave through each circle, helping to bind the service continuum together. Housing is a good example. Some people with substance use disorders often are functionally homeless, and, thus, the issue of housing permeates clinical treatment, clinical support, and community support.

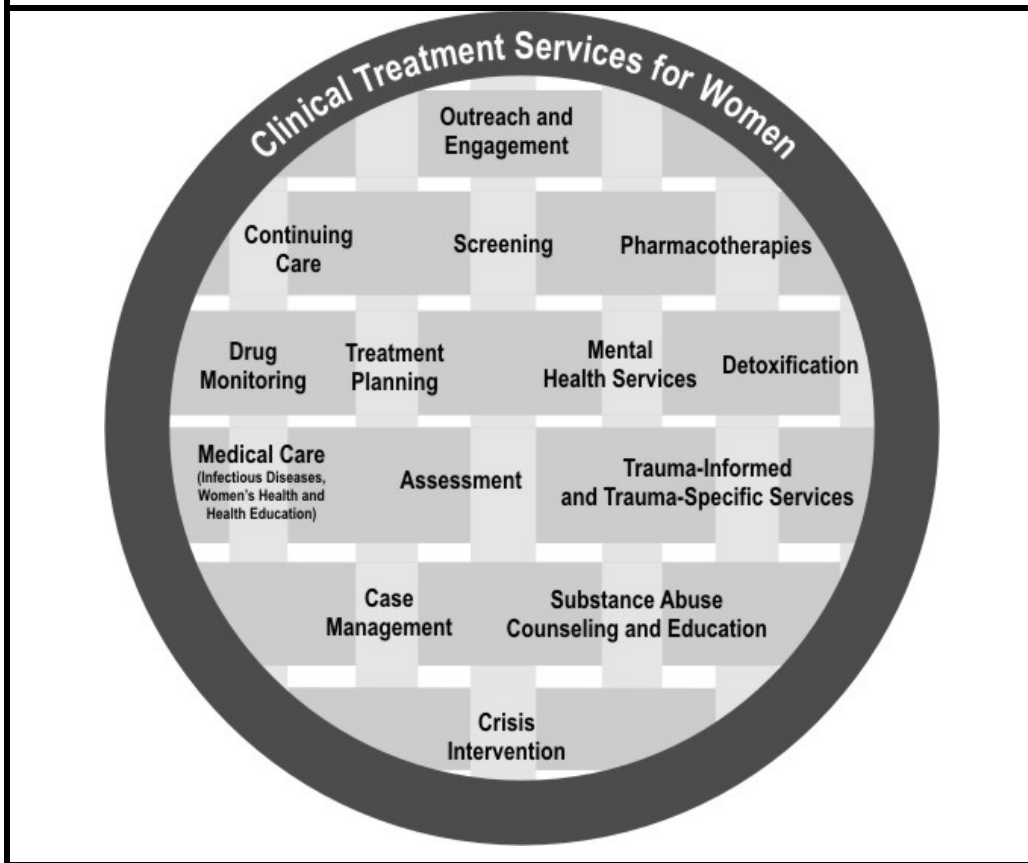
A final and critical aspect of how the circles are interrelated requires the inclusion of two concepts that provide the foundational support to the network of comprehensive care: cultural competence and gender competence. These concepts can be visualized graphically as the handles by which one can pick up and use the basket. For a system of care to be comprehensive in nature, it must have cultural and gender competence at all levels of treatment and support. The terms cultural competence and gender competence mean more than knowledge about culture or gender. They require that practitioners be knowledgeable, understanding, and sensitive to the milieu from which a woman comes because the issues and concerns she brings to treatment include the socioeconomic context of her background; her sexual identity; the sources of potential anger, pain, and fear; and disconnection from her family, friends, and community.

Clinical Treatment Services

As shown in figure 2, the fabric of the basket is interwoven with a range of clinical treatment services. These services include the following elements: outreach and engagement, continuing care, screening, pharmacotherapy, drug monitoring, treatment planning, mental health services, detoxification, medical care (including treatment for infectious diseases, women's health, and health education), assessment, trauma-informed and trauma-specific services, case management, substance abuse counseling and education, and crisis intervention. (These services are defined and further explained in the last section of this paper.) Although additional services could be included in this continuum, experience has shown that the identified elements are typical of treatment programs' core services.

For most women in treatment, particularly those burdened with issues such as intergenerational poverty, violence, and homelessness, time-limited clinical treatment services alone likely will not result in sustained recovery. Women with multiple needs require support from other systems, which are called clinical support and community support in this model, to achieve success in recovery.

Figure 2: Elements of Clinical Treatment Services for Women

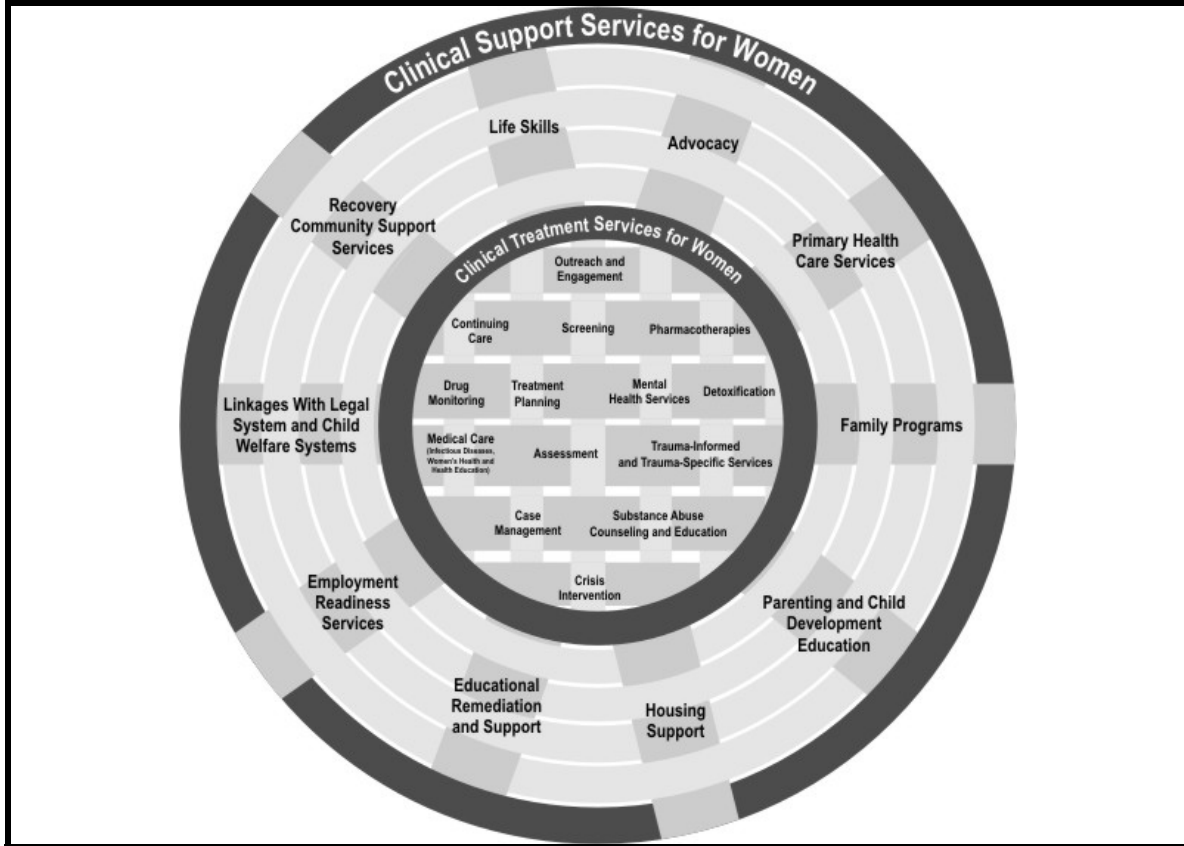


Addiction affects women's connections and relationships, causing them to leave or abandon many of the relational systems on which they formerly depended—family, friends, and roots in the community. Thus, for a woman to succeed in treatment, deliberate steps must connect her with the support structures that allow her to reverse the isolation and fragmentation often synonymous with addiction and reconnect with these important relationships. Although some connection occurs in the context of clinical treatment itself, other aspects of the reconnection process occur as a result of clinical support and community support services.

Clinical Support Services

Outside this circle of treatment services is an array of services that, by themselves, are not necessarily part of the treatment modality but, like ball bearings in relation to machinery, make the treatment modality work. These support services (shown in figure 3) include life skills, advocacy, primary health care services, family programs, parenting and child development education, housing supports, educational remediation and support, employment readiness services, linkages with the legal system and child welfare systems, and recovery community support services. Elsewhere in this document (figures 5 and 6), similar circles are identified that relate to the special needs of children. Although introduced separately, those needs are inextricably intertwined with those of the parenting woman.

Figure 3: Elements of Clinical Support Services for Women



This model suggests that clinical support services are not ancillary services or simply enhancements of treatment, but rather they are critical elements of treatment designed to promote overall well-being and prevent relapse.

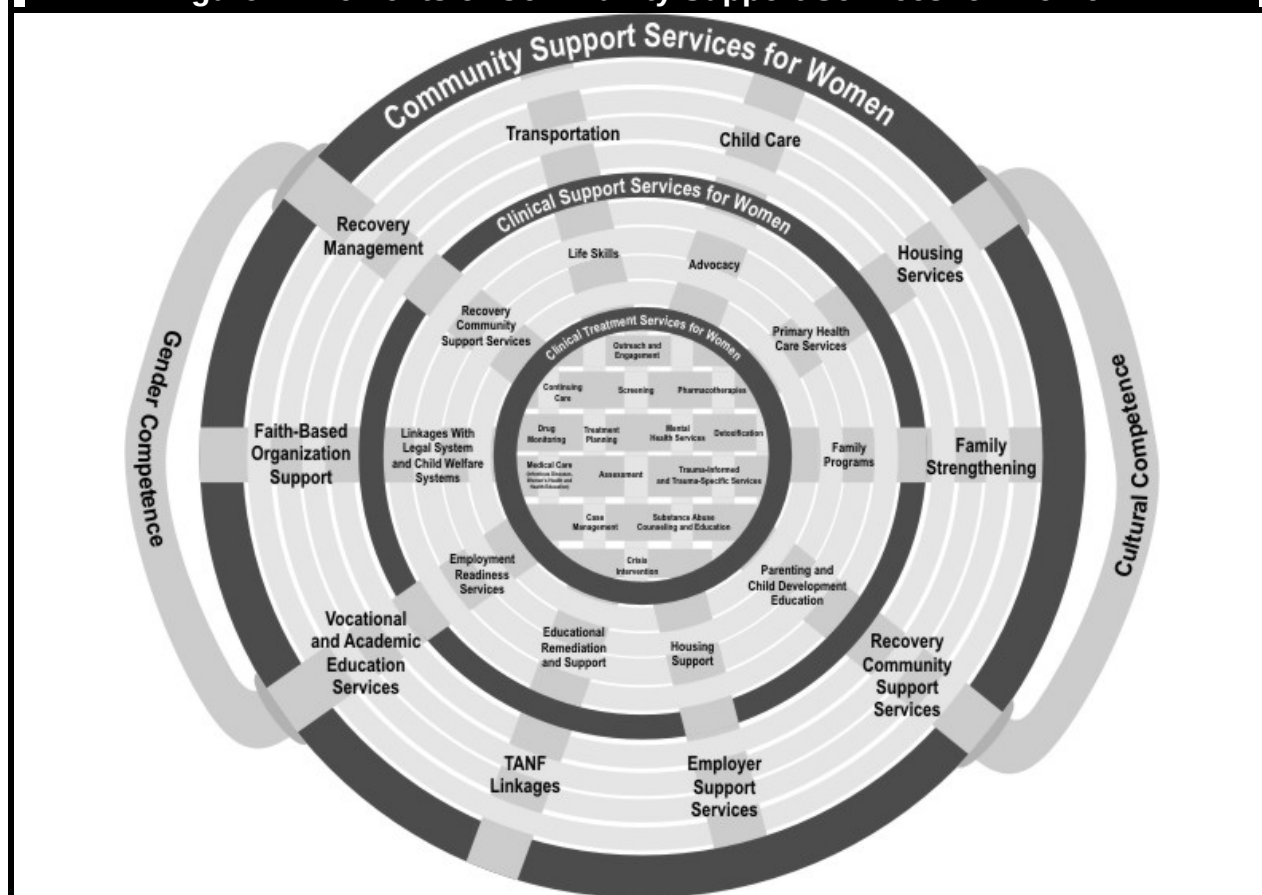
Community Support Services

Community support services are those that must be available in the community to ensure long-term recovery. These services, shown in figure 4, include transportation, child care, housing services, family strengthening, recovery community support services, employer support services, Temporary Assistance for Needy Families (TANF) linkages, vocational and academic education services, faith-based organization support, and recovery management. This circle represents some areas that are not typically included in the service array for women, but women's treatment programs and policy analysts increasingly view these elements as critical to long-term recovery.

Over the past decade, the concept of relapse prevention and aftercare evolved into the approach known as continuing care. This approach recognizes the need to provide continuing support to a person in recovery. It recognizes that treatment providers share some of the responsibility for providing such support. The concept of community support puts into operation

continuing care by recognizing the systems and services that must exist in the community to make continuing care a meaningful reality.

Figure 4: Elements of Community Support Services for Women



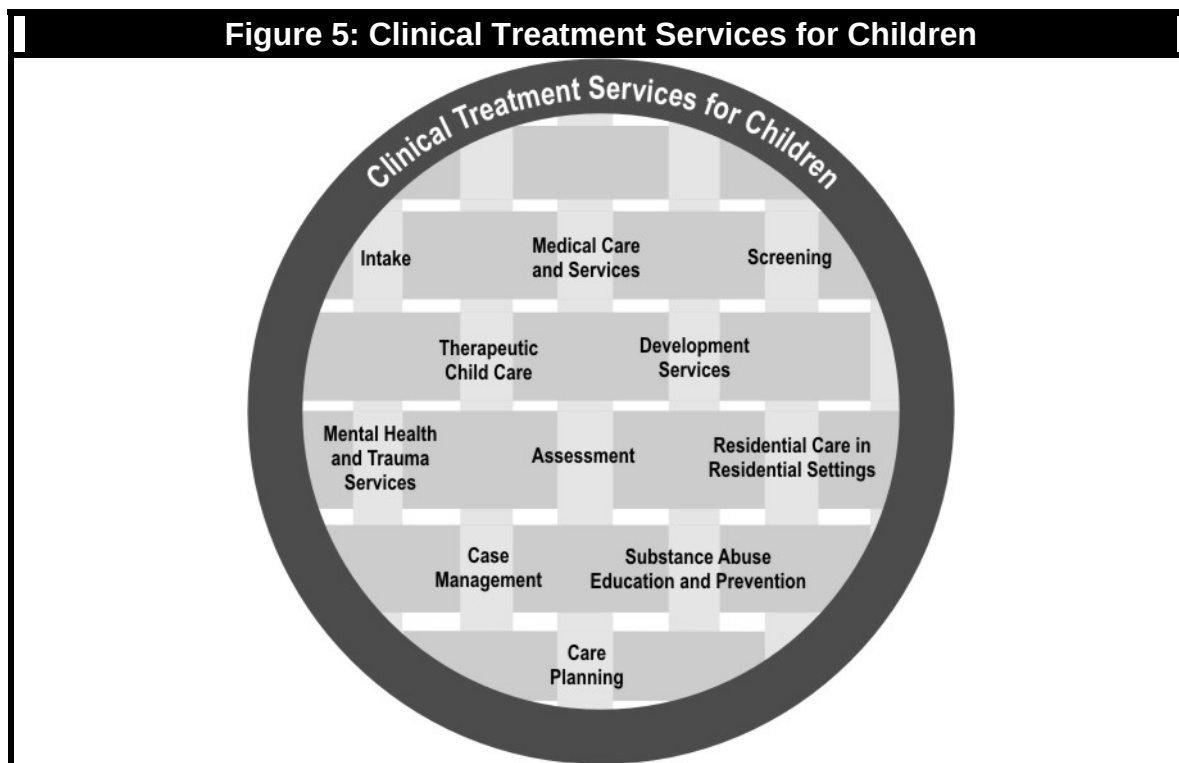
Taken together, as shown in figure 4, clinical treatment, clinical support, and community support services complete the basket and provide the comprehensive services needed by many women in substance abuse treatment. Implicit in the model is the responsibility of providers to look inward to their own resources as well as outward to community partners' resources to ensure that all elements of comprehensive services are made available in the community.

The Next Generation: Services for Children of Women in Substance Abuse Treatment

Although it is important to provide the comprehensive array of services and supports to all women, women who are mothers demand increased attention to their unique roles as parents, and their children require additional services and supports. Most mothers in treatment are the custodial parents who carry out the tasks of parenting and child-rearing. In some cases, the mother in treatment currently may not have custody and the daily responsibility for the care of her children. Those women require special considerations by treatment providers to assist the women in regaining custody if appropriate and, when regaining custody is not an option, assist women as they transition through the grieving process that may come with the permanent loss of custody of their children.

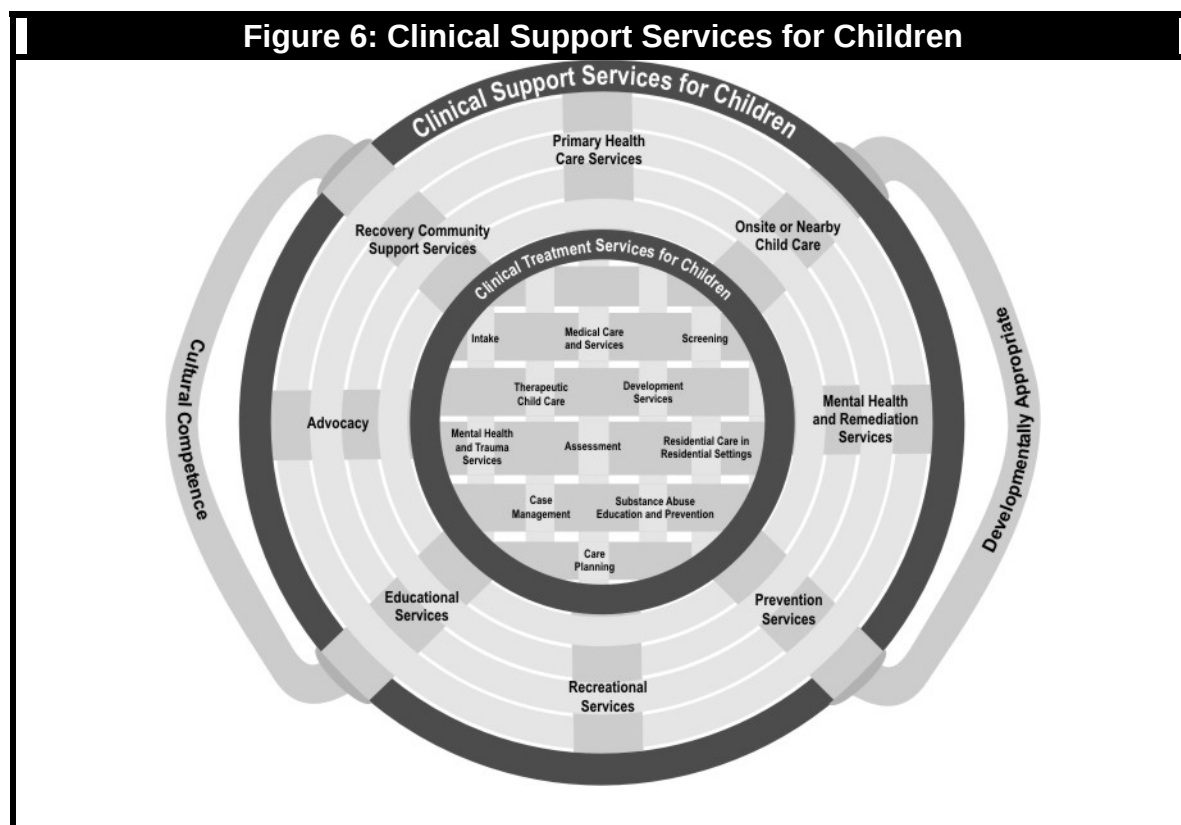
Among mothers in residential treatment who have custody of their children, the experience of the RWC and PPW programs is clear: providing child care alone is an insufficient response to the needs of children whose mothers abuse alcohol or drugs. In many cases, the children themselves needed services ranging from interventions for fetal alcohol spectrum disorders to intervention services for childhood mental disorders and developmental delays. Treatment programs have responded to the needs of children and have reported that treatment for women and their children requires a whole-family perspective in service delivery and clinical practice. Treatment agencies now understand that, for women who are mothers, their children are a major factor influencing why they enter, complete, or leave treatment.

Children's clinical treatment needs are depicted in figure 5. These needs include intake; screening for and the assessment of the full range of medical-, developmental-, and emotional-related factors; care planning; residential care; case management; therapeutic child care; substance abuse education and prevention; medical care and services; developmental services; and mental health and trauma services.



In addition, children require supports that reinforce their individual needs. These clinical support services are shown in figure 6 and include the concepts of cultural competence and developmentally appropriate services. As with the women's model, cultural competence is a critical aspect and is depicted as a handle for using the service array in the model. In addition, developmentally appropriate services for children is a critical concept to understand and address in all service delivery and represents another handle. Needs and services for young children must be tailored to their developmental status and cognition. Clinical support services include primary health care, onsite or nearby child care, mental health and remediation services,

prevention services, recreational opportunities, educational services, advocacy with treatment as well as advocacy in other service arenas and with legal issues, and recovery community supports such as peer, self-help, and mutual-support groups.



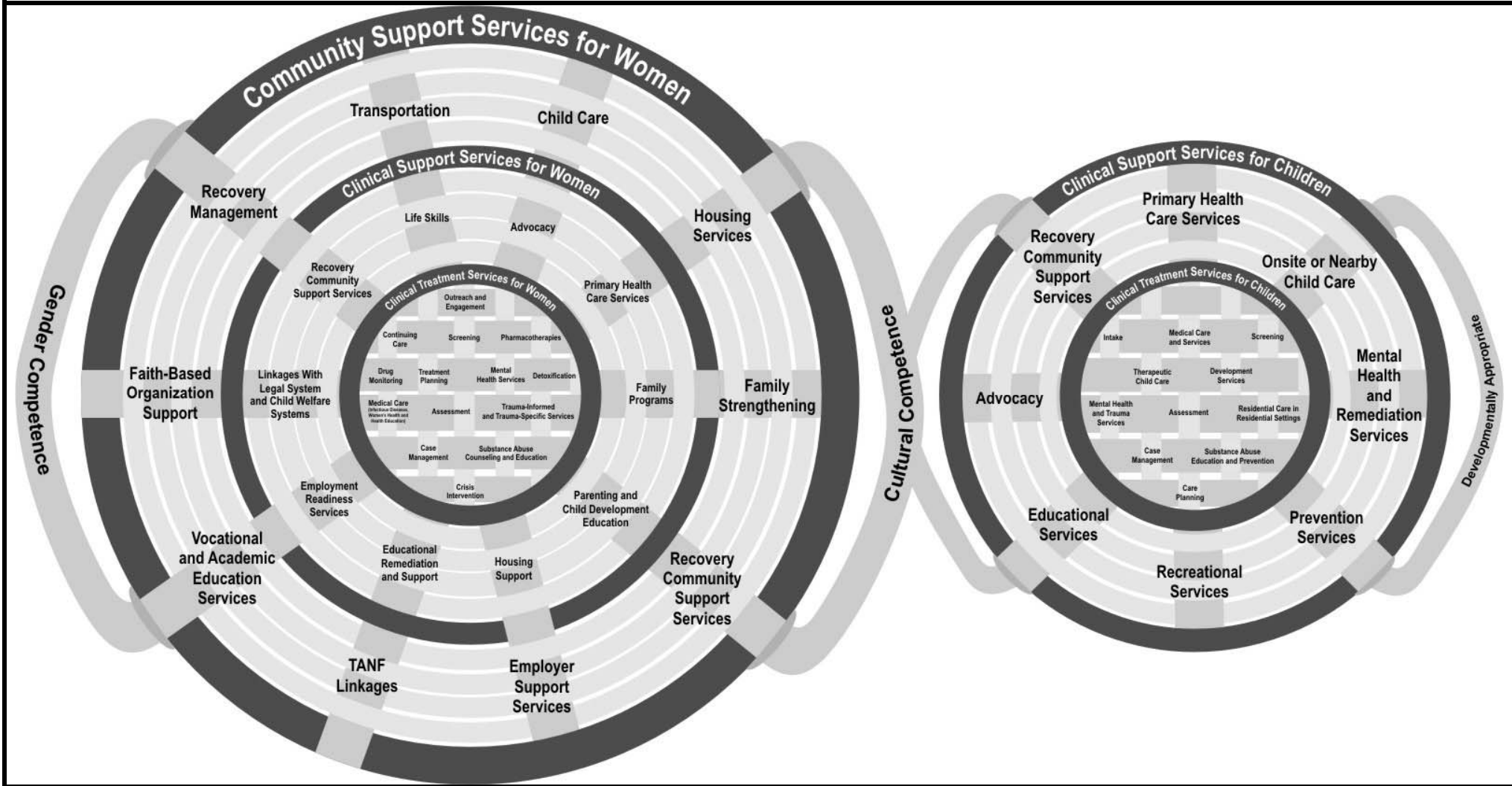
Regardless of children’s current custody status, services to address their needs should be coordinated and, when appropriate, should be integrated with their primary caregivers’ treatment and case plans to ensure that the whole family’s needs are met. Ensuring that parents’ and children’s case plans are “in sync” in terms of timing and strategies is imperative for family recovery. Although children can be significant motivators for women to seek treatment, without proper planning, caring for children also can produce stress that may contribute to relapse.

Providing comprehensive services for women and their children requires that treatment agencies provide an array of direct services as well as establish linkages to a wide range of supports and community resources to meet fully the challenges presented. This is no easy feat. The need for coordination and collaborative relationships among agencies and service systems can tax scarce resources in staff time and expertise to establish those bonds. It may seem overwhelming to consider all the various linkages needed; however, treatment agencies can prioritize their most immediate need for collaboration by understanding the most immediate needs of their clients.

Putting the Paradigm Into Operation

The elements of treatment for women and women who are mothers are depicted in figure 7 and are more fully described below. Together the elements make up the continuum of services that all women need to succeed in substance abuse treatment. The intensity, duration, and type of treatment will vary depending on the assessment and diagnosis of each woman and the needs of her child or children. The manner in which services are delivered also will vary, depending on factors specific to the women and children, including culture, race, ethnicity, social class, age, and sexual orientation. Treatment intensity, philosophy, and methods will vary depending on the needs of the client, reimbursement policies, and treatment methods used by providers.

Figure 7: Interrelated Elements of Clinical Treatment and Support Services for Women and Their Children



Clinical Treatment Services

Clinical treatment services generally are provided directly by the substance abuse treatment provider. As such, they are considered core services. Providers recognize that giving core services without support services is likely to result in less than optimum outcomes for women and children over the long-term; thus, support services are essential to the successful treatment of women and children.

Clinical treatment services for women

Outreach, engagement, and pretreatment. Activities designed to assist clients in engaging in treatment are essential elements of service, falling into the broad category of outreach, engagement, and pretreatment services. For many women, these services break the ice and help them overcome the shame and denial that often are obstacles to treatment for them. Same-day services, visits to programs, and familiarization with program staff members should be facilitated whenever possible. Identification of and attention to women's immediate needs (e.g., legal, health, safety) are important aspects of engagement, even if those problems cannot be resolved immediately. When a program slot is not immediately available, services should be offered to keep women connected to the treatment organization. Outreach for women must address barriers that keep them from treatment, such as fear of reprisal from significant others and family members, fear of not being able to care for children or the loss of custody, and language or cultural barriers. Outreach also must address systemic barriers such as lack of money or insurance, waiting lists, lack of treatment for pregnant women, absence of child care, lack of transportation, inability to find sustaining employment, and need for time to address demands of other systems, such as child welfare and TANF requirements.

- **Screening.** Intake screening is part of the admissions process and can be an important strategy that assists in engaging a woman in treatment. The interview should be relevant and sensitive to the woman's immediate needs, including the needs of her children. Intake screening should be conducted by a staff person, preferably a female, who is respectful of the complex needs of women, who is nonjudgmental, and who can determine critical immediate needs, including medical, prenatal, detoxification, housing, safety, food, clothing, urgent dental, and transportation needs. Screening provides a good opportunity to give a complete explanation of confidentiality and represents the beginning of the treatment engagement and case management process.
- **Detoxification.** Detoxification services generally are provided in an inpatient or residential setting and usually include close medical supervision. Although some treatment providers consider detoxification to be part of the continuum of care, others consider it a pretreatment activity. When needed, these services are critical to the comprehensive care model and offer another opportunity for a provider to engage a woman in longer term treatment.
- **Crisis intervention.** Women entering treatment are often victims of violence and may be experiencing crises warranting emergency intervention. Ideally, programs have crisis intervention specialists available or have established strong linkages for immediate access to crisis services. Whereas some crises may be evident at intake, others may arise during the course of treatment and may affect a woman and her children.
- **Assessment.** Full assessment for women encompasses a wide range of concerns and includes a focus on her strengths, a comprehensive view of health-related needs, risks for

HIV and other infectious diseases, psychological status and screening or assessment for disorders that commonly co-occur in women with substance use disorders (e.g., depression and posttraumatic stress disorder [PTSD]), personal and community safety issues, understanding her significant current relationships and family-of-origin factors that may predispose her to abuse substances (such as sexual, emotional, and physical abuse; neglect; parental addiction; and parental mental illness), her current parenting and care-giving roles, responsibility and issues such as custody of children, special needs of children living with her, options for care of children if the mother is to enter residential treatment without her children, her housing status and the safety of her housing, financial resources, vocational/educational/employment issues, legal issues, and involvement with other health, social, or criminal justice service systems. The information garnered in the assessment process should be the basis for a recommendation on the level of care and treatment placement. Placement decisions should follow those promulgated by the American Society of Addiction Medicine (ASAM). Known as Patient Placement Criteria (ASAM, 2001), ASAM's criteria are increasingly the standard for determining the needed level of care.

- **Treatment planning.** Treatment planning is a collaborative process that should be done in the context of the unique needs and the informed choices of women and should be based on their individual strengths. Treatment planning should include any immediately needed services to help stabilize the family and assist a woman as she prepares for treatment. Planning needs to build on the internal and external resources available to the agency and should integrate the assistance offered and stipulations required by other health and social service systems. Treatment planning with women and their children requires attention to reentry and continuing care planning as well.
- **Case management.** Case management addresses coordination of the myriad service elements that are needed by women and their families. It can occur as a pretreatment activity, during treatment, and post-treatment. Among services requiring coordination are medical, housing, child care, transportation, employment/vocational preparation, educational, and legal issues. Coordination with child protective services, welfare, and probation and parole offices also must be managed.
- **Substance abuse counseling and education.** Substance abuse counseling and education for women needs to address the dynamics associated with addiction in women, as well as current behavioral issues in her addiction and the interrelationship between addiction and other co-occurring disorders. These include issues stemming from family-of-origin dynamics and the importance of relationships in the lives of women. Counseling and education also need to address the physical and social consequences of substance use disorders. Programs should ensure that all counseling activities are conducted in a respectful and caring manner, and they should not use counseling approaches that are contraindicated for trauma survivors, such as shaming, harsh confrontation, and intrusive monitoring. Staff members should work with women in a manner that builds self-esteem, using nonaggressive and nonthreatening techniques so as not to revictimize clients. In addition, relapse prevention and recovery management are important components of substance abuse counseling and education.
- **Trauma-informed and trauma-specific services.** Given the high prevalence of histories of violence among women with substance use disorders, providing treatment in a trauma-informed environment is especially important. Staff members should be trained to understand the multiple and complex links between violence, trauma, and addiction; to understand trauma-related symptoms as attempts to cope; to understand that violence and victimization play large and complex roles in the lives of most consumers in substance

abuse and mental health services; and to behave in ways that are not retraumatizing to women. Trauma-specific services include individual and group services that directly address the effect of trauma and facilitate recovery and healing. A woman should not have to disclose her trauma history to receive trauma-specific services. Experts on serving women and trauma agree that the best practice is to enter into every treatment relationship as if the woman has experienced trauma, whether trauma is disclosed or not.

- **Medical care, including treatment for infectious diseases, women's health, and health education.** Medical assessments and subsequent care should be provided onsite or by referral by care providers who are sensitive to issues of gender, addiction, mental disorders, and trauma. The types of services that may be needed include primary care; prenatal and postnatal care; emergency and hospital care; chronic diseases care (arthritis, diabetes, etc.); testing, treatment, and counseling for HIV, tuberculosis, and sexually transmitted diseases; and gynecological care. During pregnancy, special consideration should be given to the medical management of the pregnancy. Maternal education about and preparation for delivery and postpartum needs, including postpartum relapse prevention, should be included. Methadone maintenance and medication management of opioid dependence is particularly important during pregnancy. For women with a history of mood disorder, the postpartum period should include close monitoring for psychiatric symptoms.
- **Pharmacotherapy/Medication-assisted treatment.** Medications can be combined with counseling and behavioral therapies. The Food and Drug Administration has approved medications for treatment of alcohol dependence (naltrexone, disulfiram and acamprosate calcium) and opioid dependence (methadone, buprenorphine, naltrexone). For pregnant opioid dependent women, use of methadone is the preferred standard of care. Medication-assisted treatment is usually provided from a free-standing out-patient program; however, access to a range of other interventions should also be available. During medically managed detoxification, medication use is also common. Individuals with co-occurring mental health and substance use disorders often require that pharmacotherapy be integrated with their other services.
- **Mental health services.** Provision of or linkage to psychiatric and psychological care providers is often needed, given the high prevalence of co-occurring psychiatric disorders among female substance abuse treatment clients. It is not unusual for women to need services for affective disorders, anxiety (including PTSD), and somatization disorders. Other mental illnesses including severe mental illness such as bipolar disorder or major depression are not as common but also require services among the treatment populations. Pharmacotherapy is sometimes part of mental health care, and onsite staff can provide medication education and monitoring.
- **Drug use monitoring.** Drug use monitoring, as part of the ongoing assessment of the client's progress, is a component of treatment and can be used as a deterrent to relapse.
- **Continuing care.** Continuing care is a critical element of clinical treatment services for women. Trusting relationships formed among women, their peers, and their counselors continue to provide support to women once they have completed the formal treatment period. Planning for discharge is often anxiety provoking, and counselors should be prepared for a recurrence of presenting problems and possible resistance and procrastination by the consumer. Continuing care takes place, ideally, in all three domains—clinical treatment services, clinical support services, and community support services. It addresses individual needs identified in a woman's relapse prevention plan and builds a supportive network for the woman and her family to encourage and reinforce her

recovery. When possible, a mother's schedule of continuing care services and her child's prevention services should be coordinated to encourage maximum attendance by both mother and child. A variety of mutual-help support programs also can promote the integration of the woman and her family into the community.

Clinical treatment services for children

- **Intake.** Substance abuse treatment agencies able to serve children should establish criteria that encourage enrollment of the children in the program. To provide children with developmentally appropriate services, the agency's criteria might include the child's age, as well as the number of children who may be involved for each mother. The child's safety and well-being, including bonding and attachment issues, are paramount, and any threats to these must be evaluated and considered in the intake criteria.
- **Screening.** Screening for children is an important part of providing family-centered and family-supportive treatment. It should be done in a supportive and friendly environment conducive to open dialog. There are advantages to having the person conduct the screening who later will perform the assessment.
- **Assessment.** Medical, developmental, psychological, and trauma history should be assessed for all children participating in treatment with their mothers. Particular attention should be paid to issues that require immediate attention, such as medical complications stemming from methamphetamine laboratory exposure, physical abuse, or severe neglect. As with screening, the assessment environment should be supportive, friendly, and conducive to open dialog. Determinations must be made as early as possible and should be continuously reviewed for whether a child needs education, prevention services, intervention, treatment, or a combination of these. The child's own support system should be assessed, including the role that the child's father and extended family play (or could play) in the child's life.
- **Care planning.** For children, care planning includes planning for education, prevention, and intervention services. Care planning should be conducted by professionals with particular experience in addressing the physical, psychological, and developmental needs of children whose mothers abuse alcohol or drugs. When age appropriate, care planning should include education about the treatment process that the mother will undergo and concerns about the transition that may be associated with that process.
- **Residential care in residential settings.** Providing safe and appropriate living space and adequate services for children whose mothers are in residential care is a powerful motivating factor for women to enter and continue in treatment. It enables children either to avoid separation from or to be reunited with their mother when treatment is made a condition of reunification by the courts.
- **Case management.** In addressing the service needs of children of mothers with substance use disorders, special attention should be paid to coordinating the children's services with those of their mothers. Active involvement of mothers will aid in the transition from treatment program to home. Of critical importance to care for children are the dual concepts of safety of person and stability of environment. When children are not in their birth mothers' custody, engagement of the foster or kin caregivers in care management is critical.

- **Therapeutic child care.** Children born to mothers who use substances are at high risk for poor developmental outcomes including neurological effects and alcohol-related spectrum disorders as well as consequences stemming from preterm delivery. Living with a parent with an addiction also may result in mental health issues for the children, particularly those associated with witnessing violence or separation from primary caregivers. Children with medical and mental disabilities may need specialized child care provided by professionals with advanced training and in a setting where accommodations can be made to the physical environment that is responsive to these disabilities. For example, many children may need very structured schedules, reductions in the amount of stimulation (e.g., auditory, visual, smell, temperature) in the classroom, and assistance with transitioning from one activity to another.
- **Substance abuse education and prevention.** Children whose mothers have substance use disorders need substance abuse education and prevention support at an early age, in part to correct their misconceptions of what is normal adult behavior. Programs should present information about the role of substances in the mother's role in caring for her children and put the mother's treatment in the context of the child's view of reality.
- **Medical care and services.** In addition to a focus on primary health care, attention must be given to the possibility of organic damage resulting from prenatal or early childhood substance exposure. This includes physiological damage related to alcohol-related spectrum disorders and exposure to drug production such as methamphetamine. Children living in drug-manufacturing environments may have absorbed or ingested toxic substances, and appropriate testing for toxins and medical treatment are critical for these children as their bodies adjust and eliminate the toxin. Onsite medical assessments and subsequent care should be provided when possible or by referral when necessary. The types of services that may be needed include neonatal and perinatal care, pediatric care, emergency and hospital care, and testing, treatment, and counseling for pediatric HIV/AIDS.
- **Developmental services.** Children who have been exposed to alcohol or drugs in utero or within their family environment may be at risk for physical and cognitive developmental delays. Physical, occupational, and speech therapy may be indicated for these children. Children experiencing developmental delays also may require behavior modification support, tutoring, and medication that needs to be managed.
- **Mental health and trauma services.** Children who grow up in the care of adults with substance use disorders can suffer psychological distress resulting from the experience of neglect as well as emotional, physical, or sexual abuse. Some children have witnessed domestic or other acts of violence. Children of mothers with substance use disorders often benefit from psychological counseling and therapy and by having their own trauma issues addressed through individual and group modalities.

Clinical Support Services

Clinical support services assist women in making the transition to independent and healthy alcohol- and drug-free living. They introduce or stabilize women's ability to care for themselves and their families and to fulfill their roles as community and family members. For children, these services support healthy development and increase their capacity to reach their potential.

Clinical support services for women

- **Primary health care services.** Primary health care services, which often are provided at the beginning of the treatment episode, are clinical support services (as opposed to medical interventions such as detoxification and related triage services considered clinical treatment services). These clinical support medical services include obstetric and gynecologic services, HIV/AIDS counseling, general medical and dental care, nutrition counseling, eating behavior issues, family planning, reproductive health, health education, and physical and exercise therapy. Also critical to primary health care for women are medical self-awareness, personal hygiene, and self-advocacy for wellness.
- **Life skills.** Life skills include all the activities that support independent, healthy lifestyles. They include budgeting and banking; negotiating access to services such as housing, English as a second language, income support including access to TANF, food stamps, and Medicaid; navigating legal services and commitments; setting up and running a household; grooming and clothing; recreation and leisure; preparing food and nutrition; using public transportation; and arranging for child care.
- **Parenting and child development education.** Treatment for women with children is optimized and interactions between mothers and children are improved when the women's roles as mothers are acknowledged and incorporated throughout treatment. Parenting skills are improved through education about child development and care taking, skill building, and addressing shame and guilt over past parenting activities. Mothers who are being reunited with children need support in preparation for and after the reunion. Fathers also can be important contributors to the well-being of their children and, when possible, should receive the education and support necessary to prepare them for the responsibility of parenthood.
- **Family programs.** The more psychologically and emotionally healthy a woman's significant others are, the more likely they are to help her remain engaged in treatment and recovery. Significant others should be involved in understanding family members' roles in the family and how those roles may have become maladaptive coping strategies while the woman was in active addiction. When significant others are directly involved in relapse prevention planning, they are more likely to become productively involved in supporting positive efforts at recovery and intervening when they see relapse warning signs. Family-centered programs address all members in the family and include efforts to improve relationships with significant others, including partners, parents, siblings, children, and caretakers. These family interventions can be an important part of the woman's preparation for long-term recovery.
- **Educational remediation and support.** Educational deficiencies may be a consequence of a woman's addiction or may be a significant contributor to her addiction. A lack of education is reflected in poor reading skills, conduct issues, illiteracy, special education needs, low family income, and psychological barriers associated with poor performance and low self-esteem. Cognitive impairments resulting from alcohol-related spectrum disorders and other congenital or biological origins may require significant educational supports. Establishing linkages or services to address these educational issues may be significant motivators for women to remain in treatment and provide hope for them to establish economic independence.
- **Employment readiness services.** Given the relationship of meaningful employment to recovery success and societal pressures to move the unemployed to the workforce, employment readiness services are an essential element of treatment. These services

include reading and numeric skills testing, literacy tutoring, general equivalency diploma classes, vocational assessments, pre-employment readiness training (soft skills), job referral, job retention services, and transitional employment placement. Treatment programs should establish as one of their goals the self-sufficiency of the consumer, seeking effective linkages with TANF and child welfare agencies.

- **Linkages with the legal and child welfare systems.** Many women in treatment have conditions imposed by the child welfare system to maintain their parenting role or to reunite with children who may have been removed from their custody. These requirements often include reports that progress is being made toward treatment goals, completion of parenting and anger management programs, supervised visits, drug testing, and court appearances. Communication among treatment providers, child welfare workers, the mothers' legal advocates, and the dependency court helps women move toward these goals. When mothers also are involved in the criminal justice system, linkages and communication with probation and parole staff are critical. Criminal justice requirements may include drug testing, court appearances, and documentation about treatment progress toward goals. Often these communications require access to the community's legal aid services.
- **Housing support services.** For women, particularly those with children, housing represents more than just shelter. It is a crucial support for recovery. It represents safety both for a woman and for her children. Thus, a provider seeking to provide comprehensive care must address the issue of where a woman will reside when she completes treatment and make provision for adequate housing a part of the program's continuum of care. Given the time involved in arranging for affordable, safe, drug-free housing, this service needs to be part of early planning.
- **Advocacy.** Women entering treatment often require advocates to assist them in negotiating the various systems they may need to interact with. Although direct advocacy services provide immediate access to remediation, the goal of this process is to transform women into empowered individuals who can effectively advocate for themselves and their families.
- **Recovery community support services.** Regardless of the treatment model or modality, women need to appreciate that they are not alone and that others have traveled the same road. It is critical for women to be supported in developing relationships with other women and persons in recovery who provide role models, support, friendships, and companionship in pursuing safe and sober leisure activities. Thus, early in the treatment process, providers must help women develop a gender-sensitive support network within the recovery community.

Clinical support services for children

- **Primary health care services.** Primary health care services are an ongoing need for children of mothers with substance use disorders. Monitoring medical conditions should include screening for a range of potential medical complications including effects resulting from prenatal substance exposure and risks of HIV/AIDS and other communicable diseases. Primary health care services also should focus on wellness and prevention, including immunizations and regular medical examinations.
- **Onsite or nearby child care.** Developmentally appropriate, quality child care is needed for children whose mothers participate in treatment. Child care should be onsite or proximate

to the program and should include a full range of services including therapeutic child care providing developmentally appropriate interventions as well as recreational play.

- **Mental health and remediation services.** Children whose mothers abuse alcohol or drugs often have developmental delays that require specific interventions. These children may experience higher rates of attention deficit disorder, attention deficit/hyperactivity disorder, conduct disorder, speech and language delays, and learning disabilities.
- **Prevention services.** Children whose mothers have substance use disorders are at higher risk of developing a substance use disorder of their own as they enter preadolescence and adolescence. Evidence-based prevention services tailored to these children may be most appropriate when offered in the context of the parent's own history and recovery. Prevention programs that have demonstrated their effectiveness with a range of child and adolescent populations can be found at modelprograms.samhsa.gov.
- **Recreational services.** Participation in pleasurable recreational activities helps children socialize, express themselves, relax, experience new activities, and become knowledgeable about healthful, alcohol- and drug-free leisure activities. Participation in developmentally appropriate recreational activities is a critical learning experience for children. Participation in sports, hobbies, and creative outlets also can provide vehicles for enhanced self-image and self-esteem.
- **Educational services.** Attention to the needs of school-age children, including focus on academic progress, is a necessary part of each child's service plan. Often, children in treatment with their mothers experience disruption in their academic experience because of frequent moves or other family crises. Children who were prenatally exposed to substances may have ongoing learning disabilities that require advocacy to ensure that special education services are available and to ensure children's academic success. When regular reviews of individual education plans are needed, the treatment agencies must recognize the critical role that mothers can play in attending such sessions.
- **Advocacy.** Mothers with substance use disorders may not be effective advocates for their children. Programs may need to provide direct advocacy services as well as assist mothers in developing appropriate advocacy skills to ensure that they are able to negotiate for the needs of their children. Children, as well, should be introduced to advocacy skills when introduction is developmentally appropriate.
- **Recovery community support services.** Because of the significant influence of peers and role modeling on the development of children, there is a marked need for age-appropriate recovery support activities. By building their own community of support, children can identify with peers and learn from those who have coped with similar experiences.

Community Support Services

Community support services are those that extend beyond the treatment program and are found in the community. The availability of these services helps ensure that the short-term success of treatment can be sustained in long-term recovery. Although there are additional services that women, children, and other family members may need to support the recovery of the family, those included below are some of the more common services that are used by families as they progress in their recovery.

- **Recovery management and recovery community support services.** Women continue to need community-based recovery management services including activities that provide relapse prevention and continuing care. Although these services may begin during treatment, they are part of the community-based network that supports recovery. Because of the importance of women's personal relationships, women benefit from the availability of peer-driven recovery mutual-support services, which can include Alcoholics Anonymous, Narcotics Anonymous, and Women for Sobriety.
- **Housing services.** Adequate housing is essential to attain both safety and security. Although housing services are often placed in clinical support services, in the context used here, housing services are also a community infrastructure issue. In this context, housing that encourages alcohol- and drug-free living can be a vital component for sustaining recovery.
- **Family strengthening.** Recognizing the family disruption that is common to addiction, women, particularly those who are heads of their households, need services that support the reestablishment of important family ties, including ongoing family therapy and family support services.
- **Child care.** This is an immediate, short-term treatment support service as well as a broader community service. Quality preschool, child care, and after-school care programs are longer term community supports that enable mothers to work outside the home.
- **Transportation.** Accessible and reliable transportation is important given the complicated schedules of women caretakers who often have to balance the transportation needs of their children with the transportation needs of employment and ongoing participation in continuing care.
- **TANF linkages.** With some exceptions, women from lower socioeconomic strata who progress through treatment are either TANF eligible or may become TANF eligible. TANF agencies play a role in providing support for recovery by serving as a bridge among the three circles of services, with an emphasis on work preparation and sustaining employment for women going through the recovery process.
- **Employer support services.** Communities need to create systems in employment settings that support recovery and combat workplace substance abuse. Large employers may offer employee assistance programs, and small employers may be able to coordinate needed job support services with treatment providers from their communities.
- **Vocational and academic education services.** Critical to recovery success is the continuation of educational (for women and children) and vocational services that are begun during treatment.
- **Faith-based organization support.** Recognizing that spirituality plays a crucial role in the recovery process, it is important that connections are established by treatment providers with faith-based institutions that can serve as appropriate resources for addressing the spiritual issues related to addiction and recovery. Faith-based organizations can play an important role in the community and connect families in a supportive community network.

Funding Issues

Finally, in response to the needs of providers to understand funding options for this array of services, this revision to the Comprehensive Treatment Model allows providers to identify

discrete elements of the model and make their own assessments of how to finance the elements through available funding streams. For some elements, funding will be readily available and sufficient to cover the full cost of the delivery of the services. Other elements, such as continuing care and many of the services for children are not as easily supported; providers will have to use more flexible funding to cover these services while they continue to communicate to funders that all unfunded and underfunded components are critical elements in the comprehensive model of care.

Providing comprehensive services that may be provided by separate agencies serving women and their children involves connecting the multiple funding streams that flow into the various health, human service, and educational agencies serving families. The more comprehensively a continuum of care is defined, the wider an array of funding streams are needed. The more committed an agency is to “family-centered services,” the more mastery is needed of all the different funding streams that can support families. No single agency has adequate funding sources by itself to achieve comprehensive outcomes; interagency funding streams are therefore critical to converting hopes for new linkages into reality.

Fiscal context always matters, and in tight fiscal climates tapping new sources of funding is both desired and resisted. It is desired for the obvious reason that hard-pressed agencies are anxious to find alternative funding streams to support their programs; it is resisted for the equally obvious reason that agencies seek to protect “their own” funding streams even more when funding is tight. The descriptions of funding and suggestions that follow are made in full awareness that in most States, fiscal constraints are significant factors at present.

Several issues affect the ability of programs to provide the comprehensive services needed by women and children affected by substance use disorders. Some of these issues are based on the nature of the collaborative relationship between the agencies, some flow from categorical funding constraints, and some are based on other Federal or State policies. Understanding which of these barriers are affecting a State’s or community’s ability to provide comprehensive services is a critical first step in developing their response. These concerns may include the following:

- Existing categorical definitions of funding streams and eligibility restrictions can create barriers to interagency efforts, with agency officials sometimes resistant to what seems like “one more earmark” on funding streams.
- Decisions by agencies to provide services directly or to negotiate for services with outside agencies are critical choices, but at times they may be based on limited understanding of other agencies’ funding streams.
- Each system sees the other’s funding streams as mysterious and difficult to access, and each sees its own as overcommitted and possibly threatened, leading to a debate over “your money, our money, or their money.”
- A sustained, time-consuming effort is required to achieve new Federal, State, and local collaboration, which is needed to create financing responsive to the multiple needs of children and families.
- Because the majority of funding flows through State-level government, State systems may need specific legislation to overcome categorical requirements.
- There are significant financial incentives to maintain the status quo in fragmented funding streams.

- Categorically funded programs that do not apply adequate “dosage” to ensure treatment effectiveness may require additional layers of funding from additional sources to get to a sufficient scale in the community that all persons needing the services can receive an adequate dosage of services. For example, programs that do not provide aftercare services to parents may be unable to respond to relapse issues, resulting in readmission to treatment that was under funded but ends up with a higher overall cost because of clients’ readmission.

Unified Fiscal Planning

Recently the concept of unified fiscal planning was introduced. This approach includes a variety of strategies used by States and communities to create and sustain an integrated and flexible continuum of care for children and families (Crocker 2003). Some of the more commonly used strategies include decategorization, pooled or blended funding, braided funding, wraparound, and refinancing to name a few of the more common terms given to such efforts. Often the terms are used interchangeably or without clear definition; however, the following are common definitions used for these concepts.

- Decategorization refers to State-level efforts to reduce or eliminate categorical requirements on how funds are spent. This reduction in requirements often is created in exchange for greater accountability for a set of negotiated outcomes.
- Pooled or blended funding is generally a local-level effort that is implemented among a group of agencies that formally integrates a set of funding streams into a single source of dollars. A new funding structure often is developed that administers and allocates the funds to the participating agencies based on negotiated contracts.
- Braided funding generally is implemented by an individual agency or program and refers to an administrative effort to obtain multiple funding sources to create more comprehensive services. This strategy typically works within the categorical system, and administrative responsibilities for maintaining the various categorical requirements remain.
- The term wraparound services came into use in 1986 in an article by Lenore Behar, who defined it as a way to “surround multi-problem youngsters and families with services rather than with institutional walls, and to customize these services” (Behar 1986). The wraparound approach is more a process than a service, in which a child’s or family’s individual needs are addressed by the full range of services they need, with maximum flexibility in funding.
- “Refinancing entails aggressively pursuing monies from uncapped Federal appropriations such as entitlement funds, using these new Federal funds to pay for standard services, and then applying the freed-up local and State funds to pay for alternative programs, including ... comprehensive service initiatives” (Orland et al. 1995).

Specific Treatment-Related Funding Streams

Whereas the Substance Abuse Prevention and Treatment Block Grant is still the largest source of publicly supported substance abuse treatment (approximately 40 percent), treatment providers should become familiar with the Medicaid reimbursable services in their States and learn how to bill for these services. Medicaid is a joint Federal–State entitlement program and the third largest source of health insurance in the country. It makes up approximately one-

quarter of public funds available for treatment. Medicaid coverage varies from State to State. Nearly all States restrict services when paying for alcohol and drug abuse treatment. The types of restrictions include low payment rates for treatment providers, restrictions on the settings for treatment, low limits on the days of inpatient treatment, low limits on the number of outpatient visits, and restrictions on types of providers that can be reimbursed (Legal Action Center 2002).

The Medicaid codes published by the Centers for Medicare and Medicaid Services (CMS) are also known as the HCPCS codes (Health Care Financing Administration Common Procedure Coding System). With few exceptions, all services described here as clinical treatment services for women have applicable HCPCS codes. There are fewer applicable HCPCS codes for the clinical support services for women, and HCPCS codes do not apply to community support services. As noted earlier, the existence of a code does not necessarily mean that a State reimburses for a service (at any level). States are responsible only for a short list of mandatory services, whereas most services are optional reimbursable services. CMS updates the HCPCS codes on an annual basis. Information on applicable alcohol, drug, and behavioral health HCPCS codes can be found on the Web site of the National Association of State Alcohol and Drug Abuse Directors (www.nasadad.org).

In addition to the mandatory and optional Medicaid alcohol and drug benefits, Medicaid includes a benefit known as Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) to cover both prevention and treatment services for children and adolescents younger than age 21. All children enrolled in Medicaid are entitled to EPSDT. "Under EPSDT, States must screen and then furnish appropriate medically necessary treatment to 'correct or ameliorate defects and physical and mental illness and conditions discovered by the screening services' " (Legal Action Center 2002, p. 10). In practice, use of this resource has been limited by States' ability to pay for the services. An additional source of funding for uninsured, low-income children is the State Children's Health Insurance Program, which is allocated by block grant formula to the States.

TANF can fund a range of nonmedical clinical treatment services as well as clinical support services and community support services for both women and children. The extent to which this funding is used varies greatly from State to State. Other additional valuable funding sources are available for many of the services described, although many are time limited or specialized, increasing the time demands on the provider to seek and manage multiple funding streams.

Closing Considerations

In designing a comprehensive substance abuse treatment model for women and their children, CSAT is not attempting to articulate every element of treatment. Rather, CSAT wishes to provide a standard or goal to which programs should aspire as they design and plan services that will be characterized as holistic, wraparound, or comprehensive. In addition, it is not CSAT's intention to see this model adopted without reference to the context of the community in which it is used. Thus, for the model to be truly comprehensive, it should be more than adopted; it should be adapted to its community and its consumers.

In adapting this model, different communities will emphasize different aspects. For example, the American Indian and Alaska Native communities have demonstrated the special role that spirituality, culture, and historical trauma play in treatment, and for these communities, a worthwhile adaptation requires an increased emphasis on these issues. For a community of older women, an emphasis on medication abuse also may be appropriate.

This model embodies the best practices known to CSAT, as well as the Center's experience in addressing this issue on a nationwide basis.

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