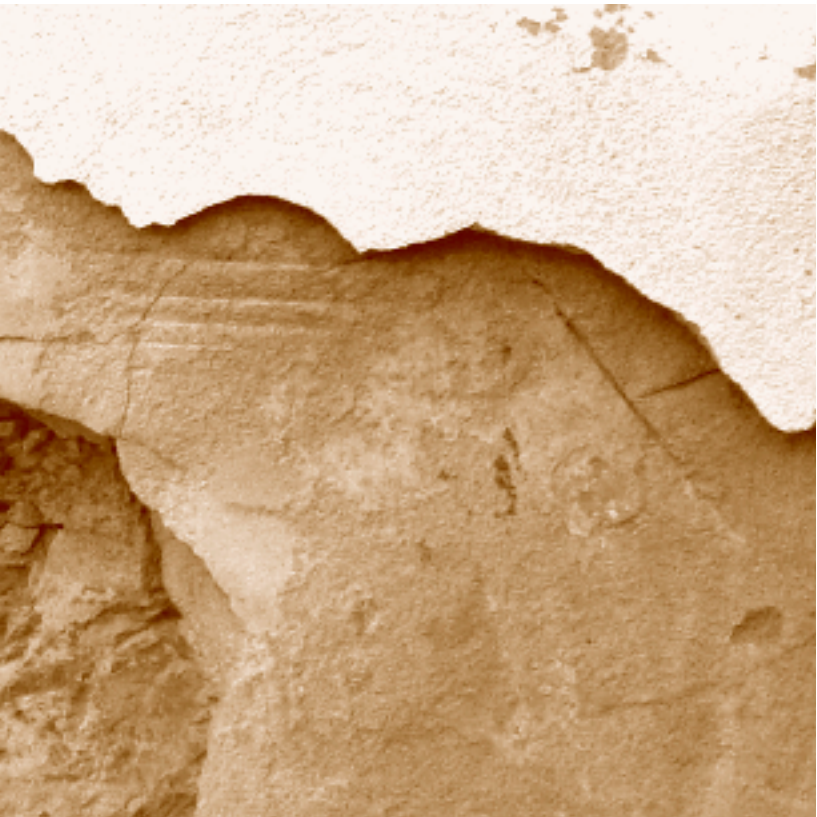




ATTACHMENT & RECOVERY:

CARING FOR SUBSTANCE AFFECTED
FAMILIES



ATTACHMENT & RECOVERY: CARING FOR SUBSTANCE AFFECTED FAMILIES

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The Connecticut Center for Effective Practice is a project directed by Robert P. Franks, Ph.D., under the auspices of the Child Health & Development Institute of Connecticut. The Center was developed in partnership between the State of Connecticut Department of Children and Families, the State of Connecticut Court Support Services Division, the Yale University Child Study Center and the University of Connecticut Health Center. This report was completed thanks to funding provided by the State of Connecticut Department of Children and Families.

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INTRODUCTION

The number of children and families affected by substance abuse in the United States is growing. There are direct and indirect implications for these children and their families, ranging from physiological issues, such as fetal exposure to drugs, to social and emotional concerns, such as separation of children from their parents and disruptions in mother-child bonds, as well as situational challenges, such as poverty and lack of housing. In order to address the needs of this population various programs have been initiated and developed over time to provide mental health, social support, medical and substance abuse treatment options to these families. Overall, these endeavors have achieved mixed results, and some types of programs and some types of treatment approaches appear to work better than others. Over the past two decades or more, there has also been a significant growth in our understanding of the characteristics of families affected by substance abuse, the common challenges that they tend to face, and the rubric of individual, family and societal factors that can impede treatment. All of this has served to further inform intervention efforts and has resulted in several innovative programs and projects geared towards meeting the needs of this population. This paper will provide a general overview of key issues that families affected by substance abuse are facing today, a description of the intervention programs that show promise of effectiveness, the core ingredients of these programs, and the lessons that we can take away from these efforts.

More specifically, the impact of substance abuse on the lives of children and families is a central focus of this paper. The topic areas highlighted in the subsequent sections were chosen to reflect this focus. As a result of substance abuse within the family, there are potential disruptions to crucial attachment relationships and bonds that can occur, which in turn, can affect infant and child development in negative ways. Other topics that will be discussed include issues that are salient for substance abuse affected families, and may also present as obstacles to the formation of positive attachment relationships if they are not adequately addressed when intervening with these families. For example, infants and children from substance abuse

affected families are often faced with multiple out-of-home placements in order to ensure that they are in a safe home environment. The section on transitions discusses how multiple placements and changes in caregivers can affect the development of attachment bonds for these children and steps that can be taken to minimize any negative effects that may result from disruptions in the child-caregiver relationship. Other sections of this paper highlight complex issues that are important to address in order to support parents in their substance use recovery efforts, keeping in mind that their health and overall level of functioning will impact their ability to care for their children, as well as to be physically and emotionally available to them. These range from the practical, yet fundamental, consideration of permanent housing for substance abuse affected families to more clinical concerns of addressing the complex treatment challenges that come with intervening with substance abusers who have co-occurring mental health problems.

SECTION 1:

INTRODUCTION TO A GROWING NATIONAL PROBLEM



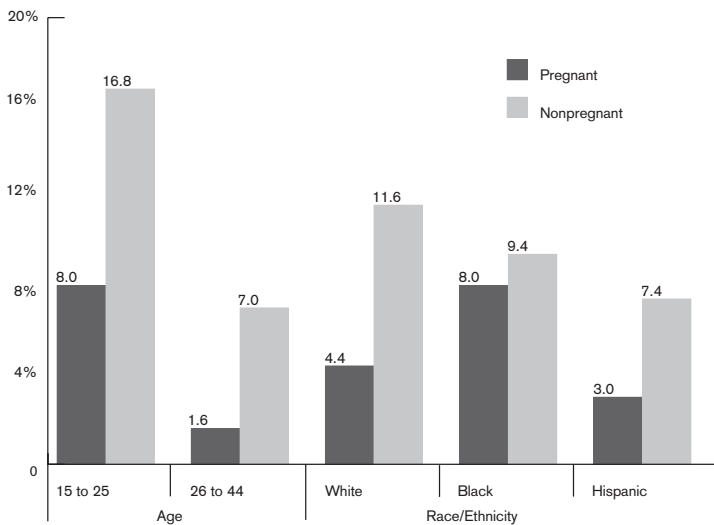
Section 1:

Introduction to a Growing National Problem

GENERAL ISSUES

National figures indicate that substance abuse is a significant problem among pregnant women and mothers. In 2002 and 2003, 4.3 percent of pregnant women aged 15 to 44 had used an illicit drug during the past month compared with 10.4 percent of nonpregnant women in this age group. Pregnant women aged 15 to 25 (8.0 percent) were more likely to have used an illicit drug during the past month than pregnant women aged 26 to 44 (1.6 percent) (Figure 1). Pregnant white women and Hispanic women had lower rates of past month illicit drug use (4.4 and 3.0 percent, respectively) than nonpregnant white women and Hispanic women (11.6 and 7.4 percent). There was little difference in past month illicit drug use between nonpregnant and pregnant black women.

Figure 1. Percentages of Past Month Illicit Drug Use among Women Aged 15 to 44, by Pregnancy Status, Age, and Race/Ethnicity*: 2002 and 2003



* The estimates for American Indian or Alaska Native, Native Hawaiian or Other Pacific Islander, and Asian respondents are not shown because of small sample sizes.

**“Pregnant women” were those women aged 15 to 44 who were currently pregnant at the time of the survey.

“Nonpregnant, recent mothers” were defined as women aged 15 to 44 who were not currently pregnant and who gave birth during the prior year.

“Nonpregnant, not recent mothers” were defined as women aged 15 to 44 who were not currently pregnant and who did not have a biological child under 1 year old in the household.

Source: SAMHSA, 2002 and 2003 NSDUH.

Recent estimates put the number of babies born in the U.S. to women who used illicit substances during pregnancy at 222,000 per year (National Institute on Drug Abuse, 1997). The rates of illicit substance use during pregnancy for White, Black, and Hispanic women are 3.6%, 6.2%, and 1.7%, respectively (Substance Abuse and Mental Health Services Administration, 2004). The direct impact of prenatal substance use on the infant is controversial, with some research demonstrating significant damage, and other research showing insignificant lasting effects (National Abandoned Infants Assistance Resource Center, December 2003). The National Center on Addiction and Substance Abuse at Columbia University (1999) reports that substance use is to blame for the dramatic rise in child welfare cases in the last two decades, and The Child Welfare League of America found that parental substance use was a factor in child removal in at least 53% of cases throughout the country (CWLA, 2003).

Substance abuse continues to be the most common factor in cases of abandoned infants and babies boarding in hospitals. Nationally, an estimated 5.5% of women used licit or illicit substances at some point during their pregnancy (Jansson & Velez, 1999). In comparison, a Department of Health and Human Services (DHHS) report found that of the children tested in 1998, 65% of boarder babies and 72% of abandoned infants tested positive for drug exposure. In 1998, of the boarder babies and abandoned infants that tested positive for substance-exposure, more than one substance could be identified in the system of each infant. Cocaine was the most frequently identified substance (DHHS, 2001).

In 1991, Congress reauthorized the AIA Act, (P.L. 102-236) mandating that programs funded through the Act give priority to infants and young children who were prenatally exposed to dangerous drugs, as well as those infected with or exposed to HIV. It also promoted the concept of comprehensive service sites; or programs offering health, education, and social services at a single geographic location in close proximity to where abandoned infants reside.

In addition, it expanded the focus of the program to include prevention, encouraging the provision of services to all family members for any condition that increased the probability of abandonment. In 1996, the AIA Act was reauthorized for an additional four years (P.L. 104-235) under the Child Abuse Prevention and Treatment Act emphasizing expedited permanency for infants.

Since the passage of the AIA act in 1988, DHHS has funded over 65 demonstration projects and a National Resource Center. As of April 2002, there were 36 AIA projects: 22 comprehensive service demonstration projects, nine family support projects for relative caregivers, and four therapeutic recreation projects for children affected by HIV/AIDS, and the Resource Center. Located in eighteen states (CA, CT, FL, GA, IL, LA, MD, MA, MI, MO, NJ, NM, NY, OK, PA, RI, TN and WV) and the District of Columbia, these diverse programs operate out of hospitals, community-based child and family service agencies, universities, public child welfare agencies, and drug and alcohol treatment centers.

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SECTION 2:

ATTACHMENT THEORY AND IMPLICATIONS FOR CHILDREN FROM
SUBSTANCE ABUSE AFFECTED FAMILIES



Section 2:

Attachment Theory and Implications for Children from Substance Abuse Affected Families

The infant-mother relationship is recognized as pivotal to a child's emerging personality. Greenspan (1997), Schore (1994), and Siegel (1999) have written convincingly about the ways that the early caregiving relationship influences the child's developing cognitive ability, shapes her capacity to modulate affect, teaches her to empathize with the feelings of others, and even determines the shape and functioning of her brain. The attachment and caregiving systems are at the heart of this crucial first relationship. However, for women and children affected by substance abuse, there are significant risk factors that leave the mother-child attachment relationship vulnerable to difficulties. Not only are there direct effects of the drugs used on parent behavior and health, there are also other risk factors associated with drug abuse, including children's prenatal exposure to drugs and parents' past experiences of trauma, that can affect the attachment bond between mother and child.

ATTACHMENT THEORY

Bowlby (1969; 1973; 1980) described the attachment and caregiving systems in biological and evolutionary terms stating that, across species, the attachment system was as important to species survival as were feeding and reproduction. At the heart of the attachment and caregiving systems is the protection of a younger, weaker member of the species by a stronger one. The infant's repertoire of attachment behaviors are matched by a reciprocal set of caregiving behaviors in the mother. As the mother responds to the infant's bids for protection and security, a strong affectional bond develops between the two, which becomes the template for the infant's subsequent relationships.

Attachment behaviors change as the child develops. A young infant who is tired, frightened, hungry, or lonely will show signaling and proximity seeking behaviors designed to bring his caregiver to him and keep her close. The infant may cry, reach out, or cling to his mother. Later when he is more mobile, he may actively approach her, follow her, or climb into her lap. A toddler may use his mother as a secure base, leaving her briefly to explore his world, and then reestablishing a sense of security by making contact with her by catching her eye, calling out to her and hearing her voice, or physically returning to her (Lieberman,

1993). By the time a child is four years old, she is typically less distressed by lack of proximity from her mother, particularly if they have negotiated or agreed upon a shared plan regarding the separation and reunion before the mother leaves (Marvin & Greenberg, 1982). These older children have less need for physical proximity with their mothers, and are better able to maintain a sense of felt security by relying upon their mental image of their mothers and upon the comforting presence of friends and other adults.

Bowlby (1969; 1982) referred to attachment bonds as a specific type of a larger class of bonds that he and Ainsworth (1989) described as "affectional" bonds. Ainsworth (1989) established five criteria for affectional bonds between individuals, and a sixth criteria for attachment bonds. First, an affectional bond is persistent, not transitory. Second, it involves a particular person who is not interchangeable with anyone else. Third, it involves a relationship that is emotionally significant. Fourth, an individual wishes to maintain proximity or contact with the person with whom he or she has an affectional tie. Fifth, he feels sadness or distress at involuntary separation from the person. A true attachment bond, however, has an additional criterion: the person seeks security and comfort in the relationship.

It is important to note that an infant does not have only one attachment relationship. Bowlby (1969; 1982) posited that babies routinely form multiple attachment relationships, arranged hierarchically, although they most likely have a single preferred attachment figure to whom they will turn in times of distress if she is available. As the infant develops, however, he will form multiple attachment bonds and an even greater number of affectional bonds. And the need for attachment bonds does not end with infancy. Across the lifespan, we all experience times when we feel weak, ill, or vulnerable and turn to a loved person for support and comfort. This turning to a preferred attachment figure is the echo of our infant attachments, and our expectations of what will happen when we turn to another when we are in distress are also built in infancy.

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Keeping these fundamental tenets of attachment theory in mind, it becomes evident that for infants and young children from substance abuse affected families, there are numerous situational and environmental factors that can jeopardize a child's formation of secure emotional bonds and disrupt their attachment to a preferred caregiver.

PATTERNS OF ATTACHMENT

The quality of the child's attachment to his mother is determined by the way the mother responds to her child's bids for attention, help, and protection. As Ainsworth (1989) pointed out, the defining characteristic of an attachment bond is that it is marked by one person seeking a sense of security from the other. If the seeker (child) is successful, and a sense of security is attained, the attachment bond will be a secure one. If the child does not achieve a sense of security in the relationship, then the bond is insecure. Ainsworth and her colleagues (1978) established the most widely used research method for assessing quality of attachment: a laboratory procedure known as the Strange Situation which involves two brief separations from mother in which the infant is left with a stranger. The infant's behavior on reunion following these separations forms the basis for classifying her quality of attachment.

Ainsworth (1978) described three basic patterns of attachment: securely attached, avoidant, and resistant. Babies described as securely attached actively seek out contact with their mothers. They may or may not protest when she leaves the laboratory, but when she returns they approach her and maintain contact. If distressed, they are more easily comforted by their mothers than by the stranger, demonstrating a clear preference for their mothers. They show very little tendency to resist contact with their mothers and may, on reunion, resist being released by her. Babies who are classified as avoidant in the Strange Situation demonstrate a clear avoidance of contact with the mother. They may turn away from her or refuse eye contact with her. They may ignore her when she returns after the separation. Some avoidant babies seem to prefer the stranger and appear to be more readily comforted by the stranger when they are distressed. The third group, resistant babies, may initially seek contact with their mothers on reunion, but then push her away or turn away from her.

They demonstrate no particular preference for the stranger, but on the contrary appear angry toward both their mother and the stranger.

A fourth pattern of attachment behavior was later described by Main and Solomon (1990), known as disorganized/disoriented behavior. These babies seem to have no clear strategy for responding to their care-givers. They may at times avoid or resist her approaches to them. They may also seem confused or frightened by her, or freeze or still their movements when she approaches them. Main and Hesse (1990) hypothesized that disorganized infant attachment behavior arises when the infant perceives the attachment figure herself as frightening. Studies have demonstrated a higher incidence of disorganized/disoriented attachment patterns in infants whose mothers report high levels of intimate partner violence (Steiner, Zeanah, Stuber, Ash, & Angell, 1994) and in infants who were maltreated (Lyons-Ruth, Connell, Zoll, & Stahl, J., 1987). The babies of mothers who abuse alcohol have also been shown to have higher incidence of disorganized/disoriented attachment behavior (Lyons-Ruth, Easterbrooks, & Cibelli, 1997). In general, infants and young children of mothers affected by substance abuse tend to be more at risk for developing attachment behaviors that are problematic, as described above.

THE ROLE OF ATTACHMENT IN EMOTIONAL AND SOCIAL DEVELOPMENT

Bowlby (1969; 1982) believed that it is by experiencing her caregiver's responses to her bids for help and protection that an infant or young child develops cognitive/emotional templates of herself and what she can expect from her relationships with other people. These templates are referred to as internal working models. An infant whose mother responds quickly and sensitively to her cries comes to see herself as worthy of attention and help. She comes to anticipate that other people in her life will respond to her positively when she needs something. She gains a sense of efficacy and agency: a belief that she can make things happen. On the other hand, a infant whose mother does not respond to her bids constructs an internal working model of herself as unworthy and other people as unresponsive

or, perhaps, as dangerous. The avoidant, resistant, and disorganized styles of attachment described above are in response to inconsistent or insensitive caregiver responses to an infant's bids. For an infant with a mother who is struggling with substance addiction and abuse, it is more likely that maternal responses to their child will be less consistent and less responsive, thereby impeding the development of healthy internal working models.

The literature suggests that the internal working models of attachment that are formed in infancy and early childhood form the templates for a variety of interpersonal relationships throughout one's life. Preschool children with secure attachment histories have been shown to be more self-confident and less dependent with their teachers than insecurely attached children (Erickson, Sroufe, & Egeland, 1985). The same children, at age ten, were less dependent on summer-camp counselors than were children with insecure attachment histories. It has also been found that securely attached six year olds were more competent in play and conflict resolution with peers than were insecurely attached children. Other researchers have found that these increased competencies extended into later childhood (Grossmann & Grossmann, 1991) and adolescence. Further, some research findings suggest that insecurely attached babies tend to develop behavioral problems during childhood. For example, it has been reported that insecurely attached boys were more aggressive than securely attached ones at four and six years of age, respectively; and Turner (1991) found that insecurely attached girls were more dependent and less assertive than securely attached girls. More recent studies have also noted that other factors besides inconsistent or insensitive maternal caregiving contribute to attachment insecurity. For instance, it has been suggested that it is more the fit between a child's temperament and a variety of environmental factors, including caregiver variables, such as child maltreatment, maternal depression and maternal substance abuse, as well as situational variables, such as level of family stress, which influences the development of insecure attachments (Greenberg, 1999). Hence, children who develop attachment difficulties due to parental use of substances or other reasons may have long term difficulties which can affect their adjustment, functioning and personality development later in life.

ATTACHMENT PROBLEMS IN YOUNG CHILDREN FROM SUBSTANCE ABUSE AFFECTED FAMILIES

Even though some studies indicate that insecure attachment styles can lead to emotional and behavioral difficulties, it is important to keep in mind that insecure attachment styles are not mental disorders. They are strategies for protection seeking on the part of the infant or young child that occur in the normative population. When the child's attempt to engage with a caregiver are frequently rejected or ignored, for example, it becomes adaptive for a young child to not expect, rely upon, or continually seek such interactions. Lieberman and Zeanah (1995) propose three separate categories of attachment disorders that tend to warrant more clinical concern: (1) disorders of non-attachment, (2) disordered attachments, and (3) disrupted attachment disorder: bereavement/ grief reaction. Of particular significance for infants and young children affected by substance abuse are the disorders of non-attachment, which closely parallel the description of reactive attachment disorder as it appears in the Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, Text Revision (DSM-IV, TR; APA, 1994). These disorders most frequently appear in children who have not had the opportunity to attach to a single caregiver, and they are of two major types, the first involving emotional withdrawal and the second, emotional promiscuity or indiscriminate behavior.

Example of non-attachment with indiscriminate behavior (Source, 1999): Susan was 15 months old when she came to live with her paternal aunt and grandmother. Until then, she had been in the care of her mother who was addicted to crack cocaine and had lived with her in a variety of crack houses and, sometimes, on the street. Her mother also had left Susan sporadically with relatives, sometimes telling them that she would be back in several hours and then not returning to retrieve her daughter for days or weeks. When Susan's mother learned of her own HIV status, she left Susan with her aunt and grandmother, saying that she could no longer care for her. Susan was physically weak, dirty and malnourished, unable even to sit up. A physical exam disclosed that she had been raped. When she was first seen in the clinic, Susan had been with her grandmother and aunt for three

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months. She had regained her physical strength and was able to stand and walk, but emotionally she was still having difficulties. She clung to both her aunt and her grandmother, screaming if they left the room and waking up in terror several times each night to make sure that they were still there. She hugged strangers in line at the bank, and when her uncles came to visit, she crawled into their laps, embraced them, and tried to remove her clothing. She approached the therapist in the very first session, clung to her knees, and sat on her lap. At the end of the hour, she sobbed when the therapist got up to leave, and could not be comforted even by her grandmother. It took many months of sensitive care for Susan to begin to develop a preference for her grandmother and to reliably turn to her for comfort.

Research on the interactions of substance abusing mothers with their infants suggests significant risk for difficulties in the mother-child relationship. In a study of infants placed with substance-abusing mothers following birth, seven percent died prior to one month of age and four percent were reported for abuse or neglect prior to six months of age (Tyler, Howard, Espinosa, & Doakes, 1997). Observations of cocaine-using mothers found they spent significantly more time disengaged from their newborns than a comparison group (Gottwald & Thurman, 1994). When compared to a control group, polydrug-using mothers are observed to be less attentive to, and less interactive with, their infants regardless of the infant's willingness to interact (Mayes, et al., 1997). Further, it is important to take into account the multitude of economic, psychological and environmental factors, including poverty, lack of permanent housing, mental illness, child abuse and inadequate parenting skills, which can have a significant impact on the home environment and parent-child relationship in substance abuse affected families. All these issues have significant treatment implications when addressing attachment problems with this population since solely focusing on maternal sobriety may not be sufficient for fostering a secure, nurturing and responsive environment.

Maternal separation from infants, which often occurs in families affected by substance abuse, may compound preexisting mother-infant interaction problems. Mothers who are separated from their infants are less likely to be familiar with the child's attachment signals. Thus, when reunification does occur, interaction difficulties are further compounded by the infant's grief over loss of an attachment figure and the mother's lack of familiarity with the infant's needs. Mothers separated from their infants may also have less understanding of, and less tolerance for, their infant's individual needs, which may inadvertently lead to an increased risk of child maltreatment (Wobie, Eyler, Conlan, Clarke, & Behnke, 1997).

According to attachment theory, the quality of care provided in the kinship or foster placement will determine the type of attachment relationship the child and caregiver develop. Although there is little empirical data available on the quality of care provided in kinship and foster placements and the establishment of healthy attachment relationships with substitute caregivers, kinship placement has been found to be safer for infants than placement with an actively substance-abusing mother (Tyler et al., 1997). There is, however, a range of care provided in kinship placements with some kinship placements failing to provide the sensitive, responsive care needed for the development of a secure attachment. Hence, number and type of placements are a significant concern when considering intervention programs and efforts for this population of children. The complex attachment challenges that can arise for infants and young children who are separated from their mothers and have to experience multiple caregiver transitions are further discussed in the next section, which addresses the issue of multiple placements for infants and young children.

**TABLE I.
POTENTIAL ATTACHMENT DIFFICULTIES IN CHILDREN
FROM SUBSTANCE ABUSE AFFECTED FAMILIES**

- Emotional withdrawal in infants whose bids for interaction are consistently unmet
- Emotional promiscuity / indiscriminate behavior – infants becoming overly attached quickly to new and multiple adult figures in order get nurturing needs met
- Mother-child relationship problems – mothers feeling disengaged from their infants; infants being less interactive with their mothers; mothers being less tuned in to their infants signals
- Maternal separation from infants and young children
- Less understanding and tolerance for infants' needs and behaviors on the part of the mothers
- Disruptions in attachment relationships due to multiple placements
- Kinship placements may not always provide an optimal nurturing environment for infants

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FOR WOMEN AND CHILDREN
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CHILD ATTACHMENT
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SECTION 3:

TRANSITIONS —
MEETING THE NEEDS OF CHILDREN EXPERIENCING MULTIPLE PLACEMENTS



Section 3:

Transitions – Meeting the Needs of Children Experiencing Multiple Placements

When families are affected by substance abuse, the attachment needs of infants are of particular concern since they are more likely than older children to be placed in foster care (George & Wulczyn, 1999). Between 1988 and 1994, 25% of first placements in foster care were infants (George & Wulczyn, 1999). A number of these infants were placed in out-of-home care as a result of prenatal exposure to maternal substance abuse (e.g., 29% of Illinois infants in substitute care in 1992).

Unfortunately, when infants are placed in out-of-home placements, they may be at increased risk of experiencing attachment disruptions that interfere with their emotional development. Loss of previously-formed attachment relationships and lack of permanence during foster care placement undermine a child's attempt to form a secure attachment with a primary caregiver. A number of the infants in substitute care are placed soon after birth and the length of time infants spend in foster care ranges from one to three years (George & Wulczyn, 1999). In the life of a young child, this spans a significant portion of a crucial developmental period when forming a secure attachment is pivotal to social and emotional growth. It is during these early years that children determine who they will view as their caregiver. As a result, infants placed in out-of-home care for several months will come to view the foster caregiver who provides for their daily emotional and physical needs as their attachment figure. Hence, it is important to keep in mind that, unless the out-of-home placement is very brief, reunification or placement in an alternative adoptive home will likely result in a significant attachment disruption.

Another issue that further complicates an already complex picture is constitutionally protected rights of biological parents. Although most agree that the bond between child and biological parent should be preserved and maintained whenever possible, practices which attempt to do so may inadvertently lead to further disruptions in the child's ability to attach to a consistent caregiver. According to Supreme Court interpretations of the Fourteenth Amendment of the Constitution, parents have a fundamental liberty interest in the control, care, and custody of their biological children. In light of this interpretation, the custodial rights of a biological parent often prevail.

At times, this may be at odds with the best interests of the child. For example, in cases where it is not deemed physically safe to return infants to the care of biological parents but there is not sufficient reason to terminate parental rights, infants may experience extended, indefinite stays in foster care in anticipation of reunification with their biological parents. An unfortunate "side-effect" of this situation is an increased risk for attachment disruptions for these infants and young children resulting from multiple placements and changes in caregivers during a crucial developmental period.

One appropriate caregiving option for children whose biological parents are unable to provide active, consistent parenting, or those who have been orphaned by the disease, is to identify members of the extended family who are willing and able to assume the role of supporting the child's psychological, physical, and cognitive development. The introduction of a member of the child's extended family or social network able to assume the role of a consistent, familiar parent surrogate may assist the child to master his feelings and cope with the reality of his situation. The child's continuing involvement with relatives enables him to retain his familial ties and, in some cases in which the biological parents are alive but unable to be daily caregivers, responds to his need to continue to see them. Kinship or extended family care has played a significant role in the rearing of children, particularly African-American children, historically and is now considered an important means of maintaining all children at risk of placement within the context of their own multigenerational histories and culture. In 1998, of the approximately 500,000 children in the United States in foster home placements, one-third to one-half were estimated to be living with relatives. For children whose biological parents are unable to provide active, consistent parenting, the extended family may be best suited to support the development of family members, a role traditionally assumed by the nuclear family. The multiple functions that continue to be served by extended families include income support, child care and household assistance, in addition to intangible supports such as emotional support, counseling and social regulation.

Section 3:

Another option is placement of children in foster care outside of the family. Among infants placed in foster care at less than a year of age, the nature of the infant-foster mother relationship is a reflection of the foster mother's attachment style. Conversely, with toddler placements, the infant/foster mother relationship tends to reflect the child's previous attachment experiences (Dozier & Stovall, 1999). Thus, toddlers placed in out-of-home care after experiencing neglect or unresponsive care may actually need more responsive care than typical toddlers.

The type of out-of-home placement most likely to interfere with the development of healthy attachment in infants and toddlers is placement in a group care setting. For example, thirteen to eighteen percent of children placed in group settings in California from 1988 to 1995 were under age six (Berrick et al., 1998). The minimum staffing ratio for infants in California group care is one adult to ten infants and there is a high staff turnover rate (Berrick et al., 1998). In light of this example, it seems unlikely that babies placed in group care will receive consistent, responsive care in these settings and have the opportunity to develop healthy attachments.

Currently, residential treatment for substance abuse typically requires women to place their children in out-of-home care. Yet, women are more likely to complete treatment if they were not separated from their children. A significant concern of women in treatment without their children is that they will lose permanent custody of their children during the treatment stay. Therefore, many mothers may terminate treatment prematurely to decrease that possibility. Women whose children are allowed to stay with them during residential treatment experience the advantage of learning parenting skills from trained personnel at the facility, observing effective parenting skills used by other mothers, and receiving feedback on their parenting styles from others. Furthermore, they may learn strategies for handling the stress of parenting. If they encounter this stress without support, their risk of relapse may increase.

In an attempt to expedite placements in a permanent setting to support healthy emotional development, concurrent planning has been promoted as a useful tool. Development of concurrent plans, when a child is in foster care, allows efforts to reunify children with their biological parents to take place simultaneously with efforts to achieve an alternative plan. Concurrent planning is one feature of the Adoption and Safe Families Act (ASFA) passed in 1997. An additional feature of ASFA is that the length of time for the biological parents to make significant progress on the goals outlined by the reunification plan is generally limited to twelve months. Both policies have the potential to reduce the negative impact of disrupted attachments experienced by young children in out-of-home placements. Concurrent planning specifically targets issues created by numerous disruptions in attachment relationships faced by infants placed in substitute care. By placing the child in the home of a foster family or family member who could become the child's adoptive family if the biological parent fails to regain custody, further disruption of attachment relationships is prevented if reunification with biological parents is not possible. Concurrent planning does not eliminate the stress that attachment disruptions cause babies and toddlers. However, it may limit the extent of the disruption by reducing the number of disruptions the child experiences.

ATTACHMENT, EARLY CAREGIVER-CHILD RELATIONSHIPS AND MULTIPLE PLACEMENTS

It is within the family that the need of all children for consistent, nurturing relationships with the adults that care for them can typically best be met. A stable, dependable relationship with a "psychological" parent allows the child to move appropriately along the developmental continuum. Through the medium of this relationship (a secure attachment), the child is able to satisfy his curiosity through safe exploration, learn to express himself, fuel his imagination and creativity, and gain trust in his world. From infancy through adolescence, the child seeks the approval of his primary caregivers as he approaches new tasks and confront new developmental, cognitive, and physical challenges.

The necessary task of seeking independence, which is central to the developmental stages of toddlerhood and adolescence, requires the stable presence of an adult, family figure from which the child or adolescent can safely separate.

Multiple placements, however, for this population of children may be unavoidable at times. This may result in disruptions in caregiving, which in turn, may evoke feelings of loss and abandonment, deprive children of the consistent relationships that foster a sense of belonging, and threaten their ability to master age appropriate tasks. These children may be less able, or unable, to form positive attachments to other adults, experience high levels of anxiety and guilt, engage in displays of socially unacceptable behaviors or experience emotional distress. Some children may act in ways that are dangerous to themselves and others out of their belief that no one will care. The child whose basic needs are unmet, who is forced to endure multiple separations from his/her mother, who spends hours worrying about her whereabouts or her safety, and who assumes the role of protector and caretaker can be diverted from his normative developmental tasks and is at increased risk for poor psychological and cognitive outcomes.

A way to address these concerns is that regardless of the placement option used, the emphasis should be on the quality of daily care that the infants and children receive. For infants who remain with a substance-abusing mother, residential treatment or extremely close supervision to ensure the infant's safety is obviously critical. The reunification of young children with a mother who has completed treatment for substance abuse is also likely to be a particularly important time for intervention for the mother-infant dyad. Although perinatal abstinence is one key aspect of facilitating positive mother-infant interactions, it may not be sufficient. Regardless of current status of sobriety, mothers with substance abuse histories often continue to require assistance in developing adaptive parenting skills. Therefore, it is essential that ongoing parent-child interventions and supportive strategies for developing adaptive parenting skills be emphasized in this population. It also is important that quality of care be considered when placing an infant in a kinship placement.

Family members of at-risk infants may face some of the same challenges to effective parenting as the infant's biological parents. Thus, it is important to determine the level of support family members will need in order to provide sensitive, responsive care. Interventions may include concrete support services such as transportation to appointments, help with child care or other responsibilities, and therapeutic services. Also, when a young child's previous experiences in relationships make it difficult for him to communicate his needs to a caregiver, it may also be necessary to work directly with the children.

Foster parents may also need guidance in how to effectively respond to the attachment needs of sick or vulnerable infants. Again, both concrete support (e.g., day care) that helps foster parents have the energy to respond to young at-risk children and consultation about the infant's attachment needs may be necessary. When infants are placed in group care, the care should simulate, as much as possible, the type of care infants receive in a family setting. Caregivers should be assigned to particular infants rather than to particular tasks. The group care should be organized such that caregivers have the time and flexibility to learn the infant's attachment needs and communications and respond to them.

When addressing the attachment needs of babies in out-of-home placements, it is important to recognize the critical importance of current caregiver relationships on young children. We need to consider both the infant's need for consistency of relationships, as well as her need for sensitive, responsive care. In some cases, it may be necessary for the infant to experience a disruption in an attachment relationship in order to have sensitive, responsive care with an alternative caregiver. In other cases, it may be possible to increase the current caregiver's responsiveness and prevent the disruption of the attachment relationship. In order to serve the best interests of the child, both these factors should be given equal consideration.

SECTION 4:
A PLACE TO CALL HOME—
HOUSING CHALLENGES FACED BY FAMILIES AFFECTED BY SUBSTANCE ABUSE



Section 4:

A Place to Call Home - Housing Challenges Faced by Families Affected by Substance Abuse

Safe and affordable housing, a critical and pervasive need for families affected by substance abuse, is in extremely short supply. This lack of appropriate housing often is a key factor in perpetuating the cycle of drug use, poverty and, in some cases, child welfare involvement. As highlighted earlier in the section on attachment, availability of permanent housing is a concrete, salient factor that can impact the ability of mothers to provide a stable home environment for their children, thereby influencing the development of attachment bonds. Unfortunately, treatment and family service providers often do not have the time or knowledge to develop, advocate for, or access such housing. At the same time, housing providers frequently are unwilling to assume the risks and costs involved in developing and/or managing housing for families with very low or no income and other social problems such as substance abuse. In addition, these housing providers tend to lack the expertise and skills to provide necessary support services to at-risk families in order to facilitate their maintenance of housing. In this section, examples of innovative, successful housing programs in order to illustrate how intervention can be implemented to address the housing challenges of children and families affected by substance abuse. The “Housing First” Model, which is based on community supported housing principles, will also be described to exemplify how we can overcome potential barriers to meeting the housing needs of this population.

EXAMPLES OF HOUSING PROGRAMS FOR AT-RISK FAMILIES

The Women’s Institute for Housing and Economic Development, in Boston, MA, is an organization that builds affordable housing for low-income women and families in an effort to foster economic independence. The Women’s Institute partners with community groups in order to provide affordable housing, economic security models, and family support programs. It builds on the strengths and experiences of low-income, homeless and formerly homeless women, and collaborates with other community-based and grassroots groups to develop projects that strengthen families and create supportive communities. The Women’s Institute has embarked on a project to develop housing for families affected by substance abuse. It has also worked to identify various obstacles to developing

affordable, supportive housing for this population, with the goal of eventually finding ways to overcome these obstacles.

The Women’s Institute has developed transitional and permanent housing in partnership with community agencies and service providers for a wide range of populations: pregnant and parenting teens, women in recovery from substance abuse, grandparents raising their grandchildren, homeless families, women with HIV or AIDS, victims of domestic violence, and linguistic minorities. The driving forces behind these residential developments have been non-profit organizations that have identified housing as a significant obstacle to their constituents’ progress. Below are descriptions of three different programs, all addressing the housing needs of families affected by substance abuse:

1) DUNMORE PLACE IN BOSTON, MA

This is a newly opened (September 2003) six-unit building of permanent apartments for women in recovery and their children. The women have graduated from a substance abuse treatment pro-gram, such as Latinas Y Niños, a residential treatment program for women with children operated by Casa Esperanza. Dunmore Place apartments provide the stable family-size housing necessary for family reunification. Dunmore Place is located next to Casa Esperanza’s residential and administrative programs, making sharing of services and personnel between pro-grams possible. Casa Esperanza also has a treatment program for men and graduate housing. Casa Esperanza adheres to a strict abstinence philosophy where no use of drugs or alcohol is tolerated. Residents who relapse are assisted with re-entering treatment, however they must start the housing process over again.

2) GRANDFAMILIES® HOUSE IN BOSTON, MA

This facility provides permanent housing for grandparents and the grandchildren they are raising. Opened for occupancy in the fall of 1998, this project provides twenty-six units of service-enriched housing for grandparents who are raising their grandchildren, many of whom who cannot live with their parents due to their parents’ addiction, other illness, or incarceration. The development also includes an apartment for the resident manager. This new model,

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the first housing of its kind in the nation, was co-developed by the Women's Institute and Boston Aging Concerns - Young and Old United (BAC-YOU). A new program of special Section 8 rental vouchers, created by both the State of Massachusetts and the City of Boston just for grandparents who are raising grandchildren, supports the Grand-Families operating budget. On-site programming, including a childcare facility and after-school enrichment and intergenerational programming, is provided by the Boston YWCA and BAC-YOU's case manager.

3) CANON BARCUS COMMUNITY HOUSE IN SAN FRANCISCO, CA

This is a supportive housing project of the Episcopal Community Services of San Francisco. It provides permanent housing for families who have experienced chronic homelessness and/or substance use issues, mental illness or HIV/AIDS. This facility provides a broad range of services for the tenants, including case management, after school and teen programs, employment assistance and a health care clinic. It also contains a childcare center and an adult learning skills center that are open to the broader community. The goal of Canon Barcus Community House is to provide families with accessible supports in order to maintain their housing and achieve their personal and family goals. This program is funded through a range of housing subsidies, including Section 8, Shelter Plus Care and HOPWA funds (Housing Opportunities for People with AIDS). A substantial percentage of the residents are current or former sub-stance users, and one of the main goals of the housing developer, Episcopal Community Services (ECS), is to provide the necessary support services to assist residents with their efforts to retain their housing. One of the unique features of their approach is the utilization of a tenant-driven model of reducing harm and achieving one's goals. This means that ECS recognizes that tenants may be unable or unwilling to disengage certain negative behaviors, such as illicit drug use, despite outreach attempts. Thus, they encourage service providers to meet tenants where they might be in terms of service needs, even though the service provided may not result in an immediate change in a negative behavior.

COMMUNITY SUPPORTED HOUSING: THE "HOUSING FIRST" APPROACH FOR FAMILIES AFFECTED BY SUBSTANCE ABUSE

Public and private solutions to homelessness have historically focused on providing homeless families with emergency shelter and/or transitional housing, which alone neither end homelessness nor prevent a recurrence of homelessness for a significant segment of the homeless population. While many homeless families are able to move into permanent housing and maintain it after an episode of homelessness, a high percentage of families are rendered homeless again when they experience their first crisis. Once in permanent housing, many families begin experiencing the same problems that led them to become homeless in the first place, and before long they are on the streets again. In fact, the Edna McConnell Clark Foundation, in its study *Families on the Move, Breaking the Cycle of Homelessness*, confirmed that recently-housed families possess the most severe risk of becoming homeless again in the near future (Notkin, Rosenthal & Hopper, 1990).

Families in which the head-of-household has a history of substance abuse are highly represented among homeless families and are particularly at risk of recurrent homelessness (Rog & Holupka, 1999; Buckner et. al, 1993). Those who are actively using drugs are usually terminated from programs that might lead to permanent housing. It is particularly noteworthy that although a parent may have successfully maintained sobriety in a recovery program, relapse often occurs once they move to permanent housing (Homes for the Homeless, 1992). Hence, the emphasis of the "Housing First" approach is to move homeless families into permanent, affordable rental housing as expeditiously as possible. This is followed by time-limited support services upon relocation out of the homeless services system.

Advocates of the Housing First model have hypothesized that vulnerable and at-risk homeless families are more responsive to interventions and social services support after they are relocated to permanent and stable housing. They also believe that homeless children are served most successfully through home-visitation support for the family unit as a whole, with stable housing providing the base.

With these tenets in mind, the Housing First approach provides a systematic, direct means for vulnerable and at risk homeless families to return to permanent, rental housing, while still receiving individualized supportive services as they develop (or re-develop) stable living patterns. It offers an individualized and structured plan of action for families that may be socially alienated or distressed in some manner, while providing a responsive and caring support system. Specifically, the program facilitates the move into permanent housing for homeless families and then engages the newly-housed family in a progressive set of individualized case management activities and interventions for a time-limited period, as the family attains improved social and economic well-being. There is some empirical evidence that supports the effectiveness of this approach in addressing the combined housing and social services needs of families with histories of substance abuse, many of whom experience ongoing or intermittent episodes of homelessness (Morse & Gillespie, 2002).

APPLYING ASPECTS OF THE “HOUSING FIRST” APPROACH

The Housing First approach lends itself well to adaptation to existing child welfare and family services programs where it can be implemented as an intermediate level intervention, particularly for families with multiple challenges, such as substance abuse affected families. The key program components include:

- 1) Crisis intervention and short-term stabilization provided by emergency shelters, transitional housing, domestic violence programs, and substance abuse treatment or recovery programs (residential or outpatient);
- 2) In-depth needs assessments to identify a family’s permanent housing and social services needs, including those of children to be reunified, which results in the formulation of a case management plan. This plan provides the foundation for both short-term and longer-term case management throughout the housing search phase, as well as after relocation to permanent housing;
- 3) Assistance provided by housing resource specialists in order to ensure that families are able to secure permanent, affordable housing as soon as possible in the intervention process. This includes obtaining move-in funds and rental subsidies, and negotiating leases on behalf of families who have multiple barriers to obtaining housing, such as poor credit, eviction histories, substance abuse histories and lack of employment;
- 4) Case management that is provided in the form of direct social services support for a transitional period of time, with a focus on household management, money management, parenting, and issues related to substance use recovery, including relapse;
- 5) Addressing families’ longer-term needs (e.g., ongoing recovery support, family counseling, and parenting education/ support) by helping them build connections to mental health and social support services in their new neighborhoods or communities.

There is some empirical support for the effectiveness of permanent housing programs in assisting at-risk families with sustaining stable and independent living arrangements. For example, in 1999, the Housing First Program in Los Angeles was chosen by the Pew Partnership for Civic Change as one of 19 sites nationwide to participate in a two-year evaluation initiative. Research was conducted by the University of Southern California, in conjunction with the Center for Urban Policy Research at Rutgers University. Quantitative data was collected on a sample of 97 families in order to measure the effectiveness of the “Housing First” methodology for those who completed six months in permanent housing. The data was collected within the first month of the family’s move and then again at the end of six months sustaining their permanent housing. The overall findings suggest that participants in the Housing First Program achieved both improved social and economic well-being and stability in permanent housing. After six months in permanent housing, 87% of substance abuse affected individuals were living drug and alcohol free, and 13% had relapsed since enrollment. However, all the families in which a parent relapsed were still able to maintain their housing while they received help in getting reconnected with their various sources of social support and/or previous treatment programs.

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FUNDING HOUSING FIRST PROGRAMS

Funding sources for the housing programs described above include private funds (e.g., from foundations and charitable organizations), as well as federal dollars from agencies such as the Department of Health and Human Services and the Department of Housing and Urban Development. However, federal dollars for such programs have diminished in recent years. Nonetheless, many social services agencies do provide home visitation to families. For Housing First, the case management interventions would focus on “stabilizing families in their housing” during the first few months, while at the same time identifying and quickly addressing signs of relapse in a parent. Many homeless services systems in communities currently provide move-in funding for families identified as “homeless” (based on HUD criteria). Collaboration with an already existing system of homeless resources and services can facilitate implementation of Housing First for families with substance abuse issues, many of whom are currently being served by mainstream health and human services systems.

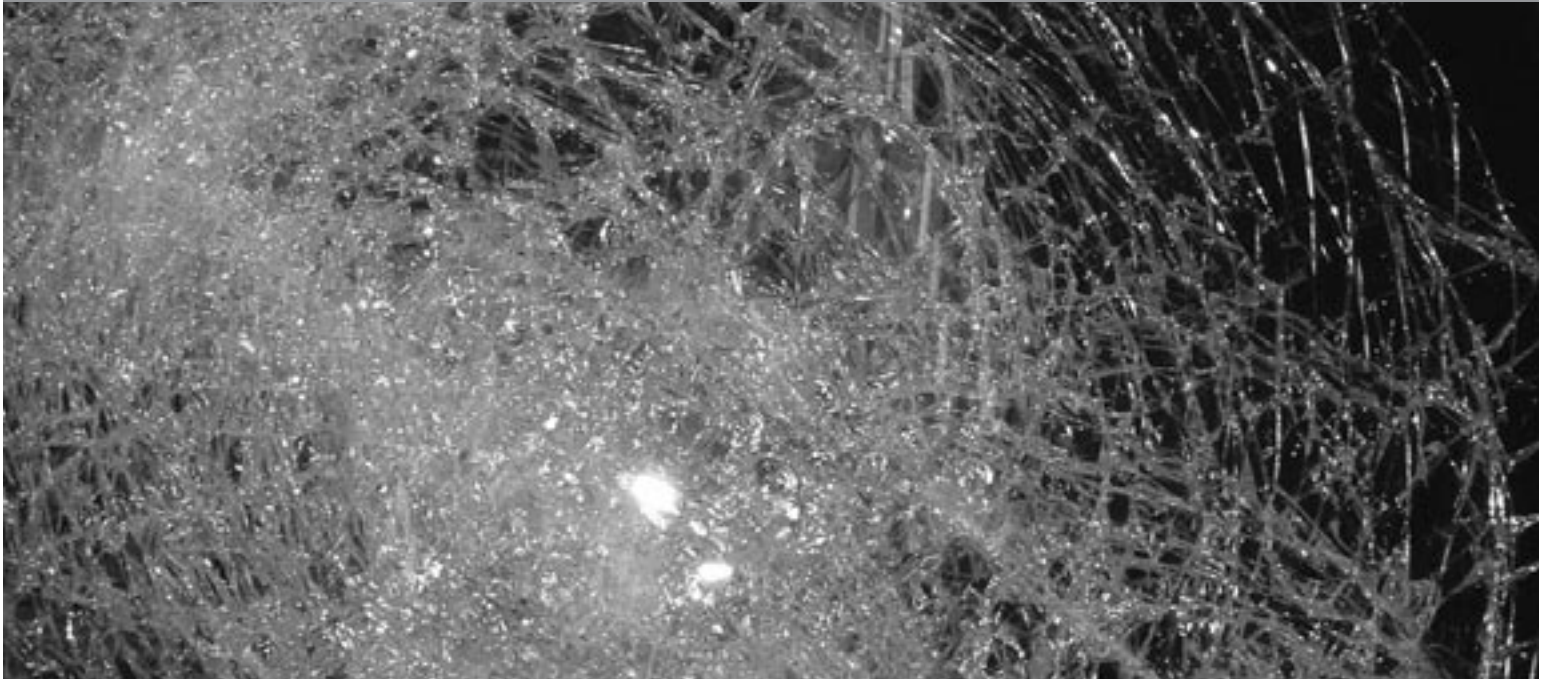
The greatest challenge is accessing subsidized housing or accessing housing that is affordable to families with limited income. Successful Housing First programs separate this function from case management and social services. This separation may be accomplished in a variety of ways, including hiring “housing staff” (preferable) or, for example, developing a collaborative effort with an existing housing counseling agency in the community at-large. For instance, in many communities, local housing authorities prioritize the provision of Section 8 subsidies to homeless families; others may maintain project-based subsidized apartments scattered throughout the community. Some housing authorities hire “housing counseling” personnel, who assist low-income tenants in accessing subsidized housing and also provide case management after the move.

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THE GREATEST CHALLENGE IS ACCESSING SUBSIDIZED HOUSING OR ACCESSING HOUSING THAT IS AFFORDABLE TO FAMILIES WITH LIMITED INCOME. SUCCESSFUL HOUSING FIRST PROGRAMS SEPARATE THIS FUNCTION FROM CASE MANAGEMENT AND SOCIAL SERVICES.

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SECTION 5:
COMPLICATING AN ALREADY COMPLEX PICTURE –
WORKING WITH MOTHERS WITH CO-OCCURRING MENTAL HEALTH DIFFICULTIES



Section 5:

Complicating an Already Complex Picture – Working with Mothers with Co-occurring Mental Health Difficulties

UNDERSTANDING WOMEN WITH CO-OCCURRING DISORDERS

Approximately seven to ten million adults in the United States have co-occurring disorders at some point in their lives (U.S. Department of Health and Human Services, 1999). Women represent 48 percent of adults with co-occurring disorders (OAS, 2004C). Because women with co-occurring disorders can and do recover, fewer women experience co-occurring mental illness and substance use disorders in any given year, compared to the number of women who experience these disorders at some point in their lives (CSAT, 2005). More specifically, according to results from the 2002 National Survey on Drug Use and Health, two million women aged 18 or older had co-occurring serious mental illness and substance use disorders in that year (OAS, 2004C).

Many women with co-occurring disorders do not attend treatment designed to treat both mental health and substance abuse problems (CSAT, 2005; Epstein Barker, Vorburger, & Murtha, 2004; OAS, 2004C). According to the results of Substance Abuse and Mental Health Services Administration's (SAMHSA) National Survey on Drug Use and Health, 48 percent of adults in the United States with co-occurring mental health and substance use disorders sought either mental health or substance abuse treatment, while only 11.8 percent of this group received both types of services (Epstein et al., 2004). Women with co-occurring disorders were more likely to receive mental health services compared with men (Epstein et al., 2004). However, many women with co-occurring disorders are treated at substance use treatment facilities, particularly residential and rehabilitative settings (OAS, 2004A). From 1995 to 2001, the number of admissions with co-occurring disorders at substance abuse treatment facilities increased from 12 to 16 percent of all admissions (OAS, 2004A).

In 2001, a majority of the adults with co-occurring disorders who sought treatment in substance abuse treatment facilities were White (74 percent), 15 percent were Black, and 7 percent were Hispanic (OAS, 2004A). This represents a sharp contrast from the racial/ethnic distribution of all other admissions, which was 57 percent

White, 23 percent Black, and 15 percent Hispanic (OAS, 2004A). However, OAS (2004A) does not provide any additional information to explain these treatment admission demographics. Non-Hispanic White women were more likely to receive any type of treatment than African American, Latino, or other women (Epstein et al., 2004).

Studies show that women with co-occurring disorders have problems in multiple contexts of life (Alexander, 1996; DiNitto et al., 2002; OAS, 2004C). Women with co-occurring disorders are more likely than men to be poor, complete fewer years of education, possess fewer job skills, receive public assistance, report more relatives with alcohol and drug problems, and care for more dependents (Alexander, 1996; DiNitto et al., 2002). Women with substance use disorders are also more likely than men to have mental disorders such as depression, anxiety, eating disorders, and lower self-esteem (CSAT, 2005). These women are also likely to have a history of victimization, homelessness, and to have experienced violence (Alexander, 1996; Najavits, Weiss, & Shaw, 1997). In a literature review by Najavits, Weiss, and Shaw (1997), it was reported that between 30-59 percent of women with substance use disorders have co-occurring posttraumatic stress disorder (PTSD). In another study of gender differences among adults with substance abuse problems, Brunette and Drake (1997) also found that women have a higher frequency of violent victimization compared with men.

Other studies suggest that women with co-occurring disorders experience a greater frequency of alcohol- and drug-related health problems, as well as medical hospitalizations for general medical conditions such as hepatitis, fractures, anemia, and kidney and bladder ailments than women in the general population (Brunette & Drake, 1997; Mowbray, Ribisl, Solomon, Luke, & Kewson, 1997). Finally, women with co-occurring disorders are more likely to have more episodes of treatment for substance abuse (OAS, 2002) and have higher rates of relapse and hospitalization (Drake et al., 2001) compared with women with either mental illness or substance use disorders alone.

Women with co-occurring disorders seem to face significantly more barriers to intervention, and as a result can be difficult to engage, successfully treat, and retain in treatment (Brown,

Huba, & Melchior, 1995). In addition to the severity, pervasiveness and volume of presenting problems that this population of women bring to treatment (Alexander, 1996), a variety of philosophical, administrative, financial, policy, family, and consumer barriers can serve to further hinder treatment (Drake et al., 2001; SAMHSA, 2002). For example, during the last 15 years, women who have sought treatment in either the substance abuse treatment or mental health system have been told to come back when their other problem is under control (Drake et al., 2001). When women with co-occurring disorders seek treatment for substance abuse, some programs have refused to allow these women to take psychotropic medication prescribed by their mental health providers (Drake et al., 2001). In addition, separate and often philosophically opposing professional training and vastly different federal policies and funding for each system continue to make treatment more fragmented and difficult for consumers to utilize (Drake et al., 2001; Osher & Drake, 1996). Caring for dependent children also represents one of the most significant barriers for women in treatment (CSAT, 2001). For example, women may avoid seeking treatment if they think it would jeopardize their custody of their children. Indeed, addressing the complex needs of women with co-occurring disorders is crucial to providing effective intervention for their children. As discussed in previous sections on attachment and multiple placements issues related to children from substance abuse affected families, addressing the multifaceted needs of mothers, particularly their psychological and emotional needs, is pivotal in optimizing the opportunities for positive mother-child bonds and reduction in the number of potential caregiving disruptions children would need to experience.

BEST PRACTICES FOR TREATING WOMEN WITH CO-OCCURRING DISORDERS

Expert consensus and empirical evidence have uncovered a number of best practices and treatments for treating co-occurring disorders in women (CSAT, 2005). Several treatment principles and modifications have been recommended to specifically address the needs of these women and their children (CSAT, 2005; Drake et al., 2001; RachBeisel et al., 1999; SAMHSA, 2002). Finkelstein, Kennedy, Thomas, and Kearns (1997) assert that women with co-occurring disorders are best served when programs

build on women's strengths and use supportive rather than confrontational approaches. In addition, some programs have seen an increase in attendance at group treatment when offering women-only groups (CSAT, 2005). Women who attend these programs report that they are more willing to attend these groups because they feel more comfortable in addressing traumatic experiences (RachBeisel et al., 1999; Watkins, Shaner, & Sullivan, 1999). Mixed-gender programs have successfully integrated women into their services by incorporating strong policies related to sexual harassment and safety, and by having a strong presence of female staff (CSAT, 2005). These programs also address the needs of women through developing programming for both women and their children.

In several literature reviews, Drake et al. (2001), RachBeisel et al. (1999), and SAMHSA (2002) agreed that effective treatment for individuals with co-occurring disorders incorporates both program level components and specific therapeutic approaches with the following common elements: a long-term approach to recovery; integrated mental health and substance abuse treatment; comprehensive focus; stagewise treatment (i.e., treatment in stages); motivational interventions; attention to women's relationships; assertive outreach; and cognitive-behavioral interventions. The following section gives a brief overview of these treatment approaches.

1) LONG-TERM APPROACH TO RECOVERY

Women with co-occurring disorders are not likely to achieve stability and functional improvements quickly (Drake et al., 2001). Based on this knowledge, effective programs have used a long-term recovery approach to help clients achieve stability over months and years in stable treatment (Drake et al., 2001). In a study comparing treatment outcomes with length of stay in two types of residential programs with clients who had not responded to previous outpatient treatment, Brunette, Drake, Woods, and Harnett (2001) found that the clients in the long-term program for an average of 624.9 days were more effectively able to reduce or eliminate active substance use compared with those in short-term treatment for an average of 66 days. Individuals in the long-term program group were also less likely to experience homelessness post-treatment compared with the short-term group (Brunette et al., 2001).

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2) INTEGRATED TREATMENT

Integrated treatment can be defined as coordinated substance abuse treatment and mental health treatment delivered by the same clinician or teams of clinicians (Drake et al., 2001; RachBeisel et al., 1999; SAMHSA, 2002). Mental health and substance abuse services have historically been offered in separate service sectors (Osher, 1996; Osher & Drake, 1996). Currently, expert consensus and emerging empirical evidence indicate that integrated services are the preferred method of service delivery (CSAT, 2005), particularly because clients with co-occurring disorders frequently have difficulty navigating multiple treatment systems (Osher & Drake, 1996; RachBeisel et al., 1999). As mental health and substance abuse treatment systems begin to join together, treatment providers in both fields can use a conceptual model, a four-quadrant framework, developed jointly by mental health and substance abuse treatment fields to provide an appropriate level of integrated services (National Association of State Mental Health Program Directors and National Association of State Alcohol and Drug Abuse Directors, [NASMHPD/NASADAD] 1999; SAMHSA, 2002). Although a full discussion of this model is not possible here, this four-quadrant framework outlines symptom severity and level of service system coordination on a continuum from less severe to more severe mental health and substance abuse symptoms (NASMHPD/NASADAD, 1999).

This framework also highlights a range of service possibilities from consultation and collaboration to integration (NASMHPD/NASADAD, 1999; SAMHSA, 2002). In this context, consultation includes referrals and requests for exchange of information from an agency designed to treat only one disorder to an agency focused on treating the other disorder (CSAT, 2005). Consultation is important during identification, prevention, or early intervention with individuals with less severe co-occurring disorders (CSAT, 2005). Collaboration is necessary when a woman can be treated at an agency designed to treat primarily either mental illness or substance abuse. When this occurs, providers can share written releases and delineate formal roles in the treatment relationship (CSAT, 2005). Individuals with severe mental illness and substance abuse symptoms need to be treated in a program that offers a range of mental health and substance abuse treatments at a single site.

Programs with fully integrated services combine the contributions of mental health and substance abuse treatment staff or cross-trained clinicians and incorporate treatments for mental health and substance abuse into a single treatment plan (CSAT, 2005).

3) COMPREHENSIVE FOCUS

For many women with co-occurring disorders, permanent change often requires addressing multiple aspects of life (SAMHSA, 2002). These women commonly need assistance to develop and maintain supports to manage both mental illness and substance use disorders while pursuing functional goals (SAMHSA, 2002). Strategies used to help women gain these skills include money management, drug testing, vocational rehabilitation, housing, and linkages with other services to provide a coordinated continuum of care (Drake et al., 2001; SAMHSA, 2002; Zweben, 1996). Drake and colleagues (2001) reported that programs, which did not offer a full continuum of services, were able to link with other organizations and, together, provide effective services.

4) STAGewise TREATMENT

Drake et al. (2001) and SAMHSA (2002) note that staged interventions have been an effective and valuable tool to help clinicians engage and retain clients in treatment by matching treatment approaches to each client's stage of motivation and treatment engagement. Two models have been created to help clinicians effectively target treatment interventions to people with mental health and substance use disorders (SAMHSA, 2002). One conceptual model, originally developed for mental health treatment (Osher & Kofoed, 1989), suggests that individuals progress in a non-linear fashion through four stages with separate clinical tasks (Drake et al., 2001; McHugo et al., 1995). During the engagement phase, clinicians give explicit attention to forming a trusting client-clinician relationship. In the persuasion phase, a practitioner's task is to help a client develop motivation to engage in treatment. During active treatment, clients work to acquire skills and functional supports for goals, and treatment providers help a client control illness. In the fourth stage, clients can use strategies for maintaining recovery and preventing relapse (Osher & Kofoed, 1989).

Prochaska and DiClemente (1992) developed a similar five-stage model for clients in substance abuse treatment, called the Stages of Change or Stages of Readiness that has been adapted for use with individuals with co-occurring disorders (Bellack & DiClemente, 1999; Ziedonis & Trudeau, 1997). This model suggests that clients experience different phases of motivation in treatment referred to as precontemplation, contemplation, determination, action, maintenance, and relapse prevention as clients progress towards healthy recovery (Prochaska & DiClemente, 1992). Movement between stages and regression to earlier stages is common, but clinicians can use both these models to appropriately adapt treatment strategies to a client's stage of treatment engagement (Drake et al., 2001).

5) MOTIVATIONAL INTERVENTIONS

Motivational interviewing, also known as motivational enhancement, is a specific technique based on theories of change (Miller & Rollnick, 1991; Prochaska & DiClemente, 1992). This technique has been used with individuals with co-occurring disorders to enhance intrinsic motivation, explore and resolve ambivalence, and develop strategies for change (Sciacca, 1997). Motivational interviewing can also be used to help people engage in treatment (Miller & Rollnick, 1991). Key elements of this technique include expressing empathy, providing feedback, avoiding argumentation, refraining from directly confronting resistance, and encouraging an individual's belief that he or she has the ability to change (Miller & Rollnick 1991). Evidence suggests that motivational interviewing is a promising approach to enhance treatment engagement. Programs have effectively used this technique with women with co-occurring disorders to improve participation in substance abuse treatment; reduce consumption of substances; and increase abstinence rates, social adjustment, and successful referrals to mental health treatment (SAMHSA, 2002).

6) ATTENTION TO WOMEN'S RELATIONSHIPS

Women's relationships are an important component of the engagement and healing process for women with both mental illness and substance use disorders (CSAT, 2005; Watkins et al., 1999). Since many women with co-occurring disorders have experienced trauma and previous victimization (Najavits et al., 1997), empathic relationships and bonding

among women are critical. In addition, treatment providers also need to address the role that women's relationships have provided in initiating women into substance use, as well as, the importance of relationships with children as a source of motivation for treatment (CSAT, 2005). Research also suggests that relationships with staff are another critical component in engaging and retaining clients (Drake et al., 2001; SAMHSA, 2002; Watkins et al., 1999).

Treatment providers can take several steps to enhance women's relationships. When feasible, providers can support the mother-child relationship by offering on-site childcare and allowing children to accompany their parent in residential treatment (CSAT, 2001; CSAT, 2005). In addition, clinicians can also explore the link between substance use and past and current relationships (CSAT, 2005). Since support networks are also crucial for maintenance of change after treatment, providers can foster re-integration among family and promote positive ties among extended family and kinship networks as an explicit component of treatment (CSAT, 2005).

7) ASSERTIVE OUTREACH

Assertive outreach, also known as Assertive Community Treatment (ACT), has been adapted from traditional case management methods for individuals with co-occurring disorders to help engage clients in treatment (SAMHSA, 2002). Common elements of this approach include extensive outreach, small caseloads, assistance with meeting basic needs (e.g., housing), a multidisciplinary team approach, provision of substance abuse treatment and mental health services within the same team, and a strong focus on the interrelationship between mental health and substance abuse (CSAT, 2005; SAMHSA, 2002). Programs have effectively used this approach to reduce noncompliance, dropout rates, and substance use over time (Clark et al., 1998; Drake et al., 2001; Meisler, Blankertz, Santos, & McKay, 1997).

8) COGNITIVE-BEHAVIORAL INTERVENTIONS

Cognitive-Behavioral Therapy (CBT) has been successfully used with individuals with co-occurring disorders to identify and replace self-defeating beliefs and actions with thoughts and behavior oriented towards coping (CSAT, 2005; Drake et al., 2001; SAMHSA, 2002). For

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example, CBT has been used to help individuals with co-occurring disorders change self-talk from statements such as, “The only time I’m comfortable is when I’m high,” to statements such as, “It’s hard to learn to be comfortable socially without drugs, but people do it all the time,” (CSAT, 1999).

CBT is commonly delivered through an individual or group modality, and several approaches are being tested and continually refined for individuals with co-occurring disorders (CSAT, 2005; SAMHSA, 2002). One CBT intervention for women with PTSD and substance use disorders may be particularly promising (Najavits, 2002). This therapy, called Seeking Safety, has been shown to reduce symptoms of PTSD and substance use in a controlled clinical trial (Hein, Cohen, Miele, Litt, & Capstick, 2004). Seeking Safety teaches women coping skills, techniques to detach from emotional pain, self-care, and finding exploring old ways of thinking and changing self-talk (Najavits, 2002). In addition, Weiss, Najavits, and Greenfield (1999) have developed a 20-session CBT relapse prevention group for people with co-occurring bi-polar and substance use disorders. This group uses two trained therapists who use non-confrontational methods to help clients gain skills in avoiding high-risk situations that commonly lead to relapse. This program also helps clients address ambivalence about treatment and develop life-style modifications to enhance self-care and self-monitoring (Weiss et al., 1999). Relapse Prevention Therapy (Marlatt, 1985) has also been integrated with CBT to help individuals with co-occurring disorders recognize cues and change the relapse process and plan a roadmap for recovery (SAMHSA, 2002).

SPECIFIC ISSUES THAT WARRANT CLINICAL ATTENTION

Beyond the above general components of treatment, there are also other treatment issues that warrant attention when working with women with co-occurring disorders. One of these issues is the use of pharmacological treatment. Psychiatric medications are now considered a vital aspect of treatment for many people with co-occurring disorders (SAMHSA, 2002). While a psychiatrist or physician with specialized training in managing co-morbid disorders should monitor the effects of these medications and

complications with drugs, alcohol, and other substances, other clinicians and service providers need to be aware of several important aspects of treatment (SAMHSA, 2002). For example, the literature suggests that people who suffer from co-occurring disorders are at a significant risk for poor medication compliance (Haywood, Kravitz, Grossman, Cavanaugh, Davis, & Lewis, 1995; Magura, Laudet, Mahmood, Rosenblum & Knight, 2002; SAMHSA, 2002; Torrey et al., 2001). When clinicians or practitioners are treating women with co-occurring disorders, clinicians can play a vital role in medication monitoring to facilitate and improve medication compliance (Baehni, 2004).

The second issue that warrants attention is pregnancy. Pregnancy may be particularly challenging for women with co-occurring disorders. For example, their symptoms of mental illness may worsen, and psychotropic medications may affect women differently during pregnancy due to varying hormonal balances (Grella, 1997; Mallouh, 1996). Mallouh (1996) recommends that social service providers ensure that women are knowledgeable and able to access needed services by offering advocacy and case management specific to issues that arise as a result of the pregnancy. During this process, it may be helpful to sensitively address a woman’s potentially ambivalent emotions, including guilt, resentment, and anxiety around the decision of whether or not to continue taking medications during pregnancy. In addition, CSAT (2005) noted that it is important to prepare women with co-occurring disorders to care for their newborns. To support pregnant women with co-occurring disorders, treatment providers can help expectant mothers by working to ensure that these women receive a constellation of family-centered and coordinated services from social workers, child welfare workers, and the foster care system (CSAT, 2005). These women and their infants would also benefit from proactive planning and consideration for how best to provide a newborn with stable and consistent caregiving to the extent possible.

There are also several specific aspects of treatment for women with co-occurring disorders that are important to consider. These include explicitly providing culturally sensitive interventions (Drake et al., 2001), offering or connecting clients with modified 12-step self-help groups (RachBeisel et al., 1999; SAMHSA, 2002), as well as consumer involvement in service planning and design in order to minimize stigma and enhance service delivery (Drake & Wallach, 2000).

TREATMENT COSTS

Costs associated with any intervention effort is often a concern. Although services for individuals with co-occurring disorders are associated with significantly increased cost compared with substance abuse treatment or mental health services alone (Dickey & Azeni, 1996; RachBeisel et al., 1999), comprehensive outpatient clinical and support services may decrease the overall financial cost in the long run (Jerrell & Ridgely, 1995). Research shows that the majority of increased service cost is associated with acute psychiatric inpatient care (Dickey & Azeni, 1996), and several interventions have been shown to reduce service costs by decreasing the need for acute services. For example, Jerrell and Ridgely (1996) compared the cost of service with treatment outcomes for individuals with co-occurring disorders who were assigned to 12-18 months of cognitive behavioral treatment (CBT), ACT, or a 12-step intervention post-discharge from inpatient care or by referral through their outpatient mental health provider. This research demonstrated that all three groups decreased the number of hospital and emergency room visits and increased their use of outpatient mental health services after treatment (Jerrell & Ridgely, 1995), thus lowering the cost of service compared with their prior histories.

CBT may be a particularly promising intervention since individuals demonstrated the greatest reduction in costs for acute mental health services, while also showing significant improvements in social adjustment and role functioning and reductions in substance use (Jerrell & Ridgely, 1995). Assertive Community Treatment (ACT) may be an additional cost-efficient treatment for individuals with co-occurring disorders (Clark et al., 1998). In a randomized controlled trial, Clark and colleagues (1998) compared the quantity

of substance use and quality of life of individuals with co-occurring disorders in ACT with similar individuals in standard case management. These researchers found that while standard case management was more cost-effective during the first two years, ACT was more efficient in the third year since these participants represented a lower fiscal and social cost for other outpatient services such as housing support, day treatment, and expenses related to arrests (Clark et al., 1998).

IMPLICATIONS OF CO-OCCURRING DISORDERS

It is evident from the discussion above that women with co-occurring disorders face significant barriers and challenges to initiation and maintenance of treatment. Although treatment costs for this particular subpopulation of individuals and their families are high and significant effort needs to be put forth to implement a coordinated treatment program that would be effective, the costs to these women, their children and society as a whole, would be much higher if appropriate steps are not taken to address their service needs.

It is essential for intervention programs to take into account the often competing needs of this treatment population and to establish ways within the intervening mechanism to systematize and consolidate the various mental health services, social services and drug treatment services. This will result in less fragmentation of care, which can lead to greater utilization and compliance with treatment across all domains. For those women who have children and families to care for above and beyond addressing their personal medical and psychological needs, increased utilization of services and compliance with recommendations from providers can lead to increased emotional availability of these mothers to their children, thereby enhancing mother-child interactions and relationships.

SECTION 6:
LESSONS LEARNED FROM NATIONAL INTERVENTION PROGRAMS



Section 6: Lessons Learned from National Intervention Programs

In response to the staggering number of abandoned infants during the 1980's, Congress enacted two laws, Public Law 100-505, the Abandoned Infants Assistance (AIA) Act, and Public Law 102-236, an amendment to the AIA Act, in order to provide appropriate care and services to infants and children affected by HIV/AIDS and substance abuse. It was this legislation that resulted in the development of AIA service demonstration projects across the country targeting this population. These projects have since been serving a highly diversified population, and have had to function under different political and policy-driven conditions. Nevertheless, AIA projects have arrived at similar conclusions regarding core components of successful intervention efforts aimed at children and families affected by substance abuse. It would be beneficial to keep these components in mind when planning new intervention efforts for this population. Provided in this section is an overview of AIA programs and the common ingredients that these programs share, which has been adapted from a 2003 monograph published by the National AIA Resource Center entitled "AIA Best Practices: Lessons Learned from a Decade of Service to Children and Families Affected by HIV and Substance Abuse."

OVERVIEW OF AIA PROJECTS

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

must be available for the multi-layered intervention ultimately employed, engagement with the family must be accomplished first.

DEVELOPMENT OF SUCCESSFUL TREATMENT INTERVENTIONS

The following is an outline of common strategies used by AIA projects across the country to engage families affected by substance abuse in comprehensive planning and intervention in order to promote safety, permanence, and well-being for their children.

1) BUILDING THE RELATIONSHIP

A major programmatic emphasis for AIA projects is establishing and building trust with their clients. Multiply challenged families have frequently experienced failure with human service agencies, and they often have an expectation of that trend continuing. They have found themselves categorized as "noncompliant" or "resistant" or have simply been discharged from programs in the past related to perceptions of their behavior. AIA staff must realize the trust issues many families bring to the relationship and be willing to prove themselves and their value to the family before engagement can be accomplished. A successful relationship cannot be built upon a prefabricated set of activities or goals imposed on families. The family must come to view the AIA team as a partner who is willing to address the whole range of strengths it possesses and challenges it faces. The trust that develops between AIA staff and clients brings about an understanding of the family members' life struggles and carries a respect for their fears, values, and priorities. In other words, it is a relationship built on working with caregivers, not for them, and recognizes that the relationship caregivers have with their children is special and must be respected. Families are considered capable of making decisions for themselves and their children. In this regard, families are empowered and respected, since the family drives the direction for success. At the same time, projects do not leave the family adrift in the process, but support them in their decision-making. Highly skilled, culturally competent, nonjudgmental staff assist families in developing realistic, flexible plans and model an ongoing process of goal setting and problem solving.

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A corresponding movement in child development addresses parallel processes that occur in ideal clinical work with caregivers and children, which highlights the importance of fostering relationships among providers, caregivers and children. This model looks at the mutual competence of supervisor-provider relationships, provider-caregiver relationships, and caregiver-child relationships, moving all three from “caretaking” to “nurturing” stages under optimal conditions. Specifically, when it is effective, the supervisor recognizes the provider as the expert of family functioning, the provider recognizes the caregiver as the expert in understanding her infant, and the caregiver, in turn, takes her caregiving cues from her infant.

Similarly, AIA project staff learned that a system of mutual respect was critical in their work with families. Each project learned how to balance respect for the caregiver as the expert and continuous assessment of child safety. At times, this meant collaborating with the family in making a referral to a child protection agency, or discussing the reasons for a potential referral with them, so that the respect between them was not broken. At other times, this was not possible and the referral was made without family input. As highlighted above, while keeping the child safe was considered paramount in AIA projects, efforts were made to address child safety in a manner that was supportive and collaborative, rather than combative. This illustrates how central relationship-building and maintaining a positive alliance with families are to the intervention efforts.

In the day-to-day work with AIA clients, projects learned that individuals affected by HIV or substance use are not solely focused on one issue. Staff learned to examine the multiplicity of issues faced by clients and to take their direction from the family in prioritizing goals. Each project found that the complexity of clients’ needs demanded broader therapeutic efforts, and a more holistic approach that addressed psychosocial and physical conditions as well as the client’s spiritual life. At the same time, goals had to be built on existing family and community ties. AIA projects also looked to the client as an agent of programmatic change. In the early years, AIA adopted a programmatic focus of short-term client involvement. However, AIA projects assumed a practice of long-term involvement upon the

discovery that it supported the engagement process and addressed the needs and solutions of families more effectively. Thus, it is clear from the lessons learned by the AIA projects, that establishing and fostering a strong, positive relationship with families not only facilitates the intervention process, but the relationship between provider and family itself is a powerful intervention.

2) SERVICE DELIVERY MODELS AND APPROACHES

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

3) MULTI/INTERDISCIPLINARY TEAMWORK

If no one project can be all things to a family, it is equally true that no single discipline can shoulder this responsibility independently. The diverse needs of AIA families (e.g., medical and behavioral health, social support, developmental services, and legal assistance) require the knowledge and skills no single profession can provide. AIA projects readily adopted the practice of multidisciplinary and interdisciplinary teamwork. With multidisciplinary work, each team member values the input from other disciplines but presents assessments, makes recommendations for services, and provides intervention independently. With interdisciplinary work, team members assume leadership in presenting their viewpoints and in sharing responsibility for the case, but reach beyond their own perspectives and training to embrace what others on the team have to offer. Team meetings are held to develop a single service plan based upon the goals developed by the individual disciplines. The key to working together is accepting that compromise is required in the process and that sometimes professional practice may indicate that additional training or group

process work must be completed before a true working collaboration can be forged. Confidentiality, as ethically understood by the various disciplines, is one of the issues that plague many teams. At a project level, supervisory tasks mandate the clarification of client confidentiality when discussing cases within an agency. For example, because of the considerable legal needs of children and families, several AIA projects include lawyers or their representatives on the teams. What information a lawyer holds as confidential may not be perceived by other team members as confidential.

It becomes critical to recognize this difference when working together on behalf of families. This stretches everyone's understanding of how to help families while learning to respect one another's point of view. AIA families are the ultimate winners in this type of collaborative relationship, since it has the potential for expanding the range of services families receive. Home visiting Most AIA projects have implemented home visiting as part of their service component, including several that began as center-based projects. Home visiting evolved in response to clients who were either unable to participate in project activities because of inadequate or a lack of childcare and transportation, or found it difficult to comply with project requirements. Rather than discharging them from the project, AIA staff began going to their homes, and was persistent in this activity, even if the family was not home or did not answer the door. By doing this repeatedly, AIA staff demonstrated a "show-of-faith" in their clients that broke the barrier of mistrust. Literally and figuratively, families were met and accepted where they were. This amounted to a somewhat radical approach to serving a group considered to be dangerous, drug using, and high risk individuals. It challenged the health care delivery system and the substance abuse treatment system, both of which expected clients to come to their offices for services.

By using the home as the primary site for service delivery, clinicians and other staff members are able to enter directly into the family's environment and gain a richer understanding of the child's world than is available in more traditional treatment settings. The willingness to go to the family's home conveys acceptance, promotes

the process of engagement, and supports the development of the therapeutic alliance that is essential to bringing about behavioral change. The experience of the AIA projects supports these assumptions and testifies to the capacity of parents, even those beset by severe psychosocial and physical adversity, to mobilize on behalf of their children's health and development with clinically informed and appropriate intervention and assistance. AIA projects have found that sustained, non-judgmental, relationship-based, in-home services offer an effective intervention for families in which children would otherwise be abandoned or at high risk of losing their parents. Both children and parents have been assisted to return to more healthy lifestyles because of this approach.

4) SOLUTION-FOCUSED APPROACH

AIA projects recognize that families often face myriad issues with which they need concrete assistance. It was recognized quickly that families did not have the luxury of long-term goal planning when faced with multiple crises. The AIA approach is a solution-focused, problem solving one. For example, projects use funds flexibly to meet identified needs that may include such items as infant supplies, diapers, formula, or developmental toys. It may also involve food purchase for the family or helping to secure birth certificates or other required identification. It may even mean assistance with rental costs, utility assistance, or payment for childcare or prescribed medication. Underlying this assistance is the ever-present need for transportation. The provision of transportation by project staff has been discovered to have intrinsic value. Not only is it required in order to secure needed services, but it also seems to be therapeutic. The staff person's willingness to provide transportation personally, often in his or her vehicle, promotes the relationship and provides a safe, contained, confidential space for discussion of difficult issues that might not occur otherwise.

5) RESIDENTIAL PROJECTS

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

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6) COMMON AIA SERVICES

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

7) COMPREHENSIVE ASSESSMENT

AIA projects use a variety of assessments to identify community and family needs. These include community needs assessments and gap analyses, infant and child development evaluation, risk identification, mental health assessments, and social support and parenting scales. Each project assesses community and family strengths and resources, as well as challenges and risks to child well-being. Projects take up to three months to complete the assessment process in order to improve the quality of information and goal setting. The development of an intervention strategy is also influenced by the commitment to long-term intervention and engagement with the family.

AIA projects have found that a careful assessment of the father is meaningful to the child and the family. The nature of the father's interactions with the family informs treatment planning and is respectful of the child's important attachments. In addition, the worker can help a woman identify the strengths and challenges of her partner relationship(s), and better determine her goals for each.

This comprehensive assessment process is ongoing and directly solicits families' perspectives. From this assessment process, the family-centered goal setting that is at the core of the intervention emerges. This approach requires balancing of competing needs – the needs of communities with the needs of individual families, and the needs of parents with the needs of their children. As a guiding principle, however, when competing needs cannot be reconciled, children's need for safety is paramount.

8) CARE COORDINATION/CASE MANAGEMENT

Case management works as a powerful therapeutic tool in AIA projects. Projects provide this service to clients based upon the assumption that the families face multiple service needs that they are unable to address on their own. The family is engaged in both identifying and meeting its own goals, so that the traditional case management approach of simply arranging services is expanded significantly. The case coordinator assists families in developing their goals, identifying their needs, and obtaining these services. It is important to keep all matters on the table for intervention and to establish realistic timetables. So, while AIA projects provide a substantial variety of services directly, advocacy with other systems is also needed.

Interdisciplinary work and multi-agency collaboration is the norm in AIA projects. This advocacy works on all levels: on behalf of individual families, on addressing the needs of the target population, and on working to coordinate all human services in our communities. Thus, the AIA projects strive to coordinate their own services and to advocate for, and integrate into comprehensive plans, the services of other systems as well. Once services are secured, ongoing interdisciplinary, multi-agency communication is essential. AIA staff often coordinates this. In some cases, families may have multiple professionals identified as "case managers" or some similar title. It is important to keep all the agencies linked to each other and connected to the family. Services must fit together and agencies must not be pursuing contradictory goals or asking families to participate in conflicting activities. For a family that may have a protective service worker, an income maintenance worker, a drug treatment professional, a probation officer, and a mental health counselor, it can become a challenge to manage all these different components without feeling overwhelmed and fragmented, instead of supported. The AIA professional is often in the role of broker and negotiator in keeping each service abreast of the activities of others and insuring that the family's goals are being voiced and pursued by all.

9) CHILD DEVELOPMENT SUPPORT

AIA projects work with family units, yet they never lose sight that these efforts support and enhance the child's

development, well-being, and safety. Optimal child development hinges upon many factors and children with prenatal drug exposure are more likely to be at risk due to a number of confounding variables in their lives that include abuse and/or neglect, poverty, homelessness, HIV/AIDS, domestic violence, and/or mental illness. AIA projects deem it critical that everyone on the team assumes the responsibility for ongoing monitoring of the child and addressing any of the potential risk factors that may hinder the child's growth and development. For these reasons, AIA projects frequently include developmental and early childhood specialists as part of the interdisciplinary team to assist and guide families in the area of parenting and to offer developmental monitoring for the children. This monitoring may include specialized care for infants identified with specific needs at birth; infant or child screenings/assessments (e.g., Bayley Scales of Infant Development II) infant massage (provided by a specialist or by a trained parent); and referrals to therapeutic early intervention services or other projects (e.g., Early Head Start). Although a developmental specialist is the ideal staff member to provide these activities, other members of the team, such as the case manager or the paraprofessional, can also provide many of these services.

10) PARENTING SUPPORT

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

11) FAMILY SUPPORT

A persistent and consistent approach with a family promotes a discovery of its power. AIA staff members offer unconditional positive regard in combination with a commitment to honest interaction. Over time, families can be convinced that service providers are genuinely interested in their goals for themselves and developing plans to reach those goals. At the same time, providers must be honest

about their own priorities, particularly around child safety and permanence.

The AIA staff can offer options, predict potential consequences of actions, and assist families in developing specific plans to accomplish identified goals. As families experience their power and build some success, it is important to provide opportunities to “give back.” Families may want to give to the project, to other participants, to other recovering people or to AIA staff. As families express this natural desire, they can be assisted to develop safe parameters for their helping, serving as a model for boundary setting and decision-making in the future. The special relationship that develops over time can create a safe environment in which to broach difficult topics. For example, families are encouraged to develop birth control plans so that pregnancies are desired and planned. Women may be assisted to deal with previous trauma including sexual assault and other domestic violence. They may decide to address sexual orientation issues that have not been dealt with.

Counseling may be provided directly by the AIA project or may be secured from other mental health professionals. Some parents need to be given permission to speak the unspeakable – that they are not able or willing to parent effectively at this point in their lives. Providing a forum for evaluating this extremely important question can empower parents to make difficult decisions on their own without coercion. Whatever the issue, the context of the relationship allows open, honest communication leading to the development of a plan of action with a resultant reinforcement of the family's abilities and the children's well-being.

12) WORKING WITH FATHERS AND FATHER FIGURES

Recognition of the importance of fathers in children's lives led to their increased involvement in AIA interventions. AIA project staff reached out to fathers or the mothers' significant others with services (e.g., support groups; parental skill building) aimed at increasing their participation. Many fathers have proven to be exemplary parents and have assumed primary caregiving responsibilities for their children. Other fathers are ambivalent about their role in the family and AIA projects help them to resolve their

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uncertainty. However, the effort to involve fathers and father figures is complicated by the prevalence of domestic violence, partner drug use, and multiple fathers and partners. Many projects have assisted fathers to enter treatment in order to become parents that are more appropriate and maintain relationships with their children. Involving fathers in treatment is a complex issue that merits much more attention than it currently receives.

13) WORKING WITH RELATIVE CAREGIVERS

As discussed earlier in the sections on attachment issues and the challenges of multiple placements for infants and children from families affected by substance abuse, the involvement of relative caregivers can serve be helpful in providing these children with more stable care. These kinship systems are often providing support both to the parents and to their children. In other cases, women are dealing with the rejection of their extended families that are no longer willing to deal with the roller coaster of substance abuse. Nevertheless, relatives frequently provide most or all of the care for children whose parents are involved with drugs. In still other families, substance abuse may be intergenerational and both parents and grandparents are substance abusers. It is important to identify and connect with this network as permitted by the enrolled family. Sometimes extended family relationships can be strengthened; sometimes they are severed. For each situation, the goal is to support the caregiving environment. Emotional support, education, emergency assistance, and access to legal services are needed for these caregivers. Extended families often need information about drug addiction and treatment and the influence of family interactions on these factors. Grandparents and other relatives need support and to know that they are not the only ones in this role. Recognizing the importance of supporting this kinship network, AIA funds have been directed to develop projects specifically for this population within AIA funding.

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FAMILY-CENTERED
SERVICES AND STRONG
COMMUNITY LEVEL
COLLABORATION
PROVIDE A SOLID
FOUNDATION FOR THE
DESIGN OF
INTERVENTIONS...
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SECTION 7:
WHERE DO WE STAND?



Section 7:

Where Do We Stand?

IMPACT OF DRUG USE ON CONNECTICUT CHILDREN

A review of child fatalities occurring in Connecticut between February, 1995 and June, 1996, found that parental substance abuse was a known factor in 55% of the cases and a possible factor in as many as 36% of the remainder. An internal study of the files of children placed out-of-home by the CT Department of Children and Families (DCF) found that 64% of the 104 records reviewed indicated that at least one member of the household was abusing controlled substances (DCF Mental Health Plan, 1996). In 1998, DCF referred 600 adult parents or caregivers for substance abuse evaluations and possible drug treatment; but 38% were unable to follow through.

A retrospective review of the medical records of children born in Connecticut to cocaine-using pregnant women between August 1, 1989 and September 30, 1990 found that by two years of age, children of cocaine-using women were 6.5 times more likely to be maltreated and 5.0 times more likely to be placed with an alternative caregiver than a sociodemographically matched sample of children whose mothers had no history of drug use (Forsyth, Leventhal et al., 1998). This study also demonstrated that children of cocaine-using women spent a significantly greater length of time in hospital not only in the neonatal period, but also during the first two years of life. In addition, a significantly greater proportion of the days spent in hospital did not meet criteria for medical necessity. The cocaine-exposed children attended significantly fewer health care maintenance visits (5.4 versus 6.5, $p < .0010$). At two years of age only 55% of the cocaine-exposed children had received their full complement of immunizations compared to 74% of the children in the comparison group ($p < .001$) (Forsyth, Leventhal, et al. 1998.)

In another study of opiate exposed infants, Stanford and Forsyth demonstrated that the mean length of hospital stay at Yale-New Haven Hospital for these infants was 50 days, (range 9-109 days); the mean charges were \$52,022 per child (range \$4,527-\$105,858) These data demonstrate clearly that children of cocaine and opiate abusing mothers are likely to experience serious deficiencies in their basic health care and costly hospitalizations without societal interest in their safety and well-being.

Parental failure to meet their needs is also more likely to place these children at risk of out of home placement and long-term involvement with protective service agencies while adding a significant economic burden to society.

Numerous studies suggest that the interaction between the prenatal drug exposure and general post-natal environmental factors may result in a range of poor child outcomes including developmental disabilities, cognitive, social, psychological, school and health problems that occur both in drug and non-drug using populations. (Lester, et al, 2004) Language development is the most common presenting problem seen in preschool children with developmental disabilities (McLean & Cripe, 1997). Moreover, language development is closely linked to the acquisition of literacy, which in turn is highly related to success and retention in school (Snow, Burns & Griffin, 1998). Children growing up in poverty and related conditions are known to be at risk for academic failure, often mediated by their lower levels of language development (Bryant & Maxwell, 1997). Thus, children in Connecticut, like other states across the nation, are faced with a wide range of challenges that impact their adjustment, health, educational achievement and overall well-being as a result of exposure to parental substance abuse.

STATE AND LOCAL RESPONSE TO SUBSTANCE ABUSE IN PREGNANCY

Prior to 1994, Connecticut was one of several states which considered and rejected a policy requiring mandatory placement of infants born to drug-abusing women in favor of developing a system of voluntary services designed to preserve familial integrity whenever possible. Following a change in state leadership and several well publicized deaths of young children whose parents were active drug users, the state became considerably more aggressive in removing children from parents who were identified as substance abusers. In March, 1994, DCF, the state child protection agency, instituted a policy mandating the investigation of all cases involving infants born to women abusing drugs or with severe mental retardation or major psychiatric illness. An analysis of data supplied by DCF reveals that this policy has resulted in a dramatic increase in the number of drug-affected children

removed from their home. Prior to the implementation of the policy approximately 4200 child placements were observed on January 1 of each year between 1983 and 1993. Between 1994 and 1996 the number of children in placement on January 1 rose to 10,166 indicating the immediate effect of the state's punitive policy towards substance using mothers and their infants.

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NUMEROUS STUDIES SUGGEST THAT THE INTERACTION BETWEEN THE PRENATAL DRUG EXPOSURE AND GENERAL POST-NATAL ENVIRONMENTAL FACTORS MAY RESULT IN A RANGE OF POOR CHILD OUTCOMES INCLUDING DEVELOPMENTAL DISABILITIES, COGNITIVE, SOCIAL, PSYCHOLOGICAL, SCHOOL AND HEALTH PROBLEMS THAT OCCUR BOTH IN DRUG AND NON-DRUG USING POPULATIONS.

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SECTION 8:
INTERVENTION EFFORTS IN CONNECTICUT



Section 8:

Intervention Efforts in Connecticut

There are currently two programs in Connecticut that have been developed to address the needs of infants and children affected by substance abuse, the Yale Coordinated Intervention for Women and Infants (CIWI) and the PROkids Plus program. These programs developed through support from the AIA, provide examples of initiatives within the State of Connecticut that have attempted to address these issues in a coordinated, comprehensive manner. By examining these efforts, state policy makers, administrators and child welfare and clinical providers can learn from them and build on their successes. Below are descriptions of the CIWI and PROkids Plus programs, as well as preliminary research findings related to program outcome, provided by the respective program directors.

CIWI PROGRAM DESCRIPTION

CIWI is an intensive, in-home, wraparound service for substance abusing women and their infants. All services are provided by a team composed of a master's level clinician (social worker, psychologist or nurse) and a family support worker, (FSW), who is often a person in recovery. Team members are available by beeper for crisis management and client emergencies 24 hours a day, 7 days a week. The intervention is structured in three phases (1) engagement and relationship building, (2) intensive intervention and referral, and (3) stabilization and maintenance. The clinician's initial task is to develop a working formulation of the main problem, the behavior that may lead to the potential removal of the child from the home, in the context of the family's strengths and vulnerabilities as outlined in the following four domains: (1) the parent or caregiver individually, (2) the parent or caregiver and the family, (3) the parent or caregiver and the environment and (4) the parent or caregiver and the health system.

The role of the clinician is to assess each family member's immediate needs and identify the level of intervention necessary for the family to address them. This task precedes the formulation of a comprehensive treatment plan that is developed collaboratively with mother and other relevant family members. Family support workers are frequently individuals from the same ethnic and cultural background as the client population. Many clients are able to develop a trusting relationship with these natural helpers from their

own community, thus enhancing their ability to use the services more easily and effectively. During the engagement and relationship building phase, the team joins with the family to identify the problems the family wishes to address, works together to implement the plan designed to meet the family's basic needs, and links the family with appropriate health and social services to ensure that the child and family receive the comprehensive services they require.

During the Work and Action Phase of the intervention, team members meet with the family in their home, individually or together, at least twice per week, and supplement this contact with phone and face-to-face contacts with the appropriate family members, collateral contacts and professionals. Treatment plan objectives may include assisting the family to obtain health, mental health, legal, respite, educational, and social services for the child and other family members, or to develop a permanency plan for the child. Enrollment and adherence to substance abuse treatment are primary goals for CIWI clients. When appropriate, the team assists mothers to protect their children when they feel the need to use drugs by involving someone else willing to provide safe, temporary care. When there is a need for parents to identify and use alternative, more permanent caregivers, the team will help them accept and carry out the plan that calls for the child to be raised by someone else. When this occurs, our services are offered to the alternative caregiver as well. The team and the family regularly assess progress towards goal attainment and make changes as adjustments to the treatment plan as needed.

The aims of the Ending and Wrap-Up phase of the intervention are to maintain the family's gains, empower the family members, create a discharge plan and, when appropriate, finalize permanency planning for the child and provide parallel services to the alternative family in the interest of the child's on-going placement stability. During this period, face-to-face contact with the family is reduced gradually to once per week or less.

The team now plans to contact the family by letter, phone and or home visit dependent on the clinical needs of the family in the months following the formal termination

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of home based services. These contacts, at three and six months post termination will be used to provide the family with supportive services both directly and through community referrals.

OUTCOME DATA ON THE CIWI PROGRAM

Program outcomes to date are reviewed in terms of description of children and caregivers enrolled in the CIWI program, caregiver-child nurturance and relationship at program completion, child maltreatment and placement with family, adherence to pediatric care, goal attainment, successful completion of the CIWI intervention, and dissemination of knowledge. Provided below is a summary of findings in several of these domains.

Since program inception, 180 mother-infant pairs have received CIWI services. The majority were biological parents with their children residing in their homes. Women received a wide array of services concurrent with their CIWI enrollment. Most rated their experiences in the program positively, although, highlighting the need for greater specification of strategies for engagement and retention, many were discharged from the program prior to completing their treatment goals. As detailed earlier, women enrolled in the CIWI program were largely single parents, of ethnic minority backgrounds with limited educational attainment, few financial resources and insufficient prenatal care. The majority, approximately 77% has a history of crack cocaine abuse. An additional 9% had histories of opiate abuse. Alcohol and other drugs were commonly abused as well.

The CIWI program engaged families around a broad range of treatment goals ranging from an initial focus on establishing a therapeutic alliance to assistance with benefits and legal matters to psychological treatment goals related to substance abuse, child development and parenting. Based on data gathered on a total of 43 families served from 2000 to 2003, the number of families who met specific treatment goals ranged widely from 42 to 97 percent depending on the nature of the goal.

Measures of successful completion of the CIWI Program were derived from clinical administrative data collected between 1996 and 2003 at the time of intake and

discharge and included variables related to mother and child demographics, service use and psychosocial functioning. The following variables were found to relate to successful completion of the CIWI Program: less than high school education at intake and termination, presence of employment income at termination, termination due to successful completion of treatment goals, child protective service referral during treatment, length of treatment in days, referral from a hospital program, substance abuse treatment within six months prior to intake, and residing in a house at termination.

In general, preliminary findings from the CIWI Program suggest that families who, over the course of the CIWI intervention, experienced greater psychosocial stability and a greater duration of service, were more likely to derive benefit in terms of stable placement of children with family members and completion of CIWI treatment goals.

PROkids PLUS PROGRAM DESCRIPTION

PROkids Plus is a center and home based intervention program for infants and children with prenatal substance exposure in Hartford, Connecticut. Its goal is to promote resilience and optimal development through enhancing the postnatal care-giving environment. The components of the program include enhanced primary care in which visits are increased in frequency and duration, home visitation and family development, developmental assessment, collaboration with community agencies, and advocacy. The team consists of a combination of professionals and paraprofessionals with the latter doing most of the home visits under supervision of clinical social workers. Thus, there are frequent touch points for parenting intervention by workers with varied levels of skill. All staff receive training in motivational enhancement therapy, trauma sensitive care, and attachment. The intervention begins with newborns and follows them through 5 years of age. It is most intense in the first 18 months and then dosage is adjusted according to the needs of the family. Although infants with their biological mothers are the focus, PROkids works with other attachment relationships such as fathers, domestic partners, and alternative caregivers.

In the absence of a parenting model that fits well with the needs of our program and families, we developed an attachment-based model, called “Empathic Care.” This approach provides parenting intervention “on the go.” Every encounter is considered therapeutic, in which the child’s needs and the parenting interaction are held in mind and addressed as crisis and non-crisis intervention is provided. The strong undercurrent of this intervention is empathy, which we define as the ability to feel for another and show compassion while maintaining healthy psychological boundaries. In this way, we hope to reach into the care-givers’ own affective areas, promoting healing and enhancing their emotional development so that they may have the capacity to respond more sensitively and be available to their infants. Two essential techniques are utilized:

- 1) Pivoting the caregiver’s consciousness to the child so that the needs of the child and relationship are not lost in the myriad of other seemingly more pressing needs. Thus, the developmental timeline of the child does not fall victim to the needs of the caregiver but both are addressed in parallel.
- 2) Parallel processing by which the approaches, strategies or behaviors exercised between the team and the caregiver mirror those between the caregiver and child. Relationships between staff members and with the caregiver are as necessary and important as that between the caregiver and the child.

OUTCOME DATA ON THE PROkids PROGRAM

There is descriptive data available on the children and families served by from 2000 to 2003. Families served were from diverse ethnic and racial backgrounds. Majority of the mothers were single-parents and had not completed high school. The mothers who had been served in this program tended to present with numerous problems aside from substance abuse, including psychiatric/mental health difficulties, legal problems, history of domestic violence and homelessness. Many of the children in the sample served had experienced disruptions in their attachment relationships and had experienced placements outside of their home.

SECTION 9:
CONCLUSIONS AND RECOMMENDATIONS



It is undeniable from reviewing the existing literature that meeting the challenge of providing effective interventions for children and families affected by substance abuse can seem daunting. The needs are great and the obstacles to intervention are numerous. However, there is significant promise and positive signs as well. Studies and theories regarding a variety of salient issues related to this population, such as attachment relationships between child and caregiver, multiple vulnerabilities associated with substance abuse, and the importance of permanent housing to recovery and sobriety, provide a solid foundation on which to build a conceptually sound intervention program. In addition, initial program evaluation and treatment outcome research suggest that certain approaches work better than others. These are all steps in the right direction and future efforts to initiate an intervention program, or to augment an existing service, would do well to build upon the knowledge base that already exists.

As a summary to this paper, here are some closing points and recommendations to highlight key issues that were addressed:

1 NEED FOR COMPREHENSIVE COMMUNITY-BASED TREATMENT FOR CHILD & FAMILY

Common themes that are highlighted across diverse treatment programs serving an equally diverse population include the importance of the community-based, multi-disciplinary approach to intervention and the importance of meeting the needs of individual families. It appears that successful intervention programs do not merely focus their efforts on a single factor (e.g., maternal sobriety), nor do they measure a family's success in such narrow terms. There is a delicate balancing act of being aware of, and bringing together, all the components of treatment that a family may need, but always meeting them where they are in the recovery process in order to maintain their engagement.

- Attention to sobriety of the parent alone is not sufficient to meet the needs of the affected family.
- Programs for families affected by substance abuse must place an emphasis on the well-being of children, as well as the parent-child relationship.

- Programs should be comprehensive, collaborative and multidisciplinary, focusing on the complex and multiple needs of families.
- Programs should be community-based and engage multiple providers.
- Key stakeholders should be identified, engaged and work together to develop a comprehensive system of care.
- Programs should leverage resources of the community, region and state to ensure the full range of comprehensive services is made available to children and families.

2 IMPLICATIONS OF ATTACHMENT THEORY

The attachment bond between a young child and a consistent caregiver is seen as the cornerstone of healthy, normative development through infancy and childhood. Given the high potential for disruption in the mother-child relationship, as well as multiple disruptions in caregiver-child relationships as a result of multiple placements, it is crucial that intervention efforts keep in mind the importance of developing and maintaining positive attachment bonds for infants and young children in this population.

- Programs should be implemented, such as the CIWI program in New Haven, CT and the PROkids Plus program in Hartford, CT, that are mindful of the importance of attachment and work to address various factors involved in fostering an environment for children that is conducive to the forming of positive attachment relationships.
- Intervention efforts should include a focus on maintaining positive bonds between mothers and children in order to facilitate healthy attachment.
- When possible, interventions made in the best interest of the child and family should not further disrupt healthy attachment.

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- The degree and scope of disruption in the lives of children affected by substance abuse extends beyond attachment relationships and permeates all aspects of a child's development. Therefore, interventions need to be focused at both the child and family level.

3 NEED TO ADDRESS HOUSING CHALLENGES

In light of the complex nature of working with substance abuse affected children and their families, innovative intervention programs that address needs across multiple domains, such as housing, and bring together existing community resources with additional vital components may be particularly helpful. For example, The Housing First approach described previously could be a helpful approach not just to provide housing for high risk and vulnerable families with children but also to integrate services provided to this population. This approach provides a systematic, direct means for families in which a head-of-household is in recovery to return to independent living and stability in the community, with a time-limited relationship designed to empower without engendering dependence.

- Securing and maintaining permanent housing can play a pivotal role in immediate recovery and sustained sobriety.
- Having a permanent place to call home also has long-term implications for the well-being of children from substance abuse affected families. Physical stability and permanence provided by long-term housing allows a child to feel physically safe, setting the stage for healthy development.

4 IMPLEMENT BEST PRACTICES

Families and children affected by substance abuse often face a myriad of challenges and obstacles to recovery simultaneously. When considering intervention options, it is important to conceptualize an intervention approach that can meet these different needs in a manner that supportive and therapeutic for the individual family. This was clearly illustrated in the section on interventions for women with co-occurring disorders. Women with both mental illness and substance use disorders frequently come to treatment with a history of multiple risk factors and it is during the treatment process that screening for these

multiple risk factors, completing a thorough assessment, and providing appropriate referrals need to occur in order to appropriately match an individual's stage of recovery and stage of treatment engagement with the treatment package.

- Treatment strategies should be based on best practices, such as those endorsed by AIA programs, yet individually tailored to meet the needs of each family.
- Best practices should be adopted and adapted to the community context and existing resources should be leveraged to build community capacity.
- Best practices should be integrated into community systems of care to ensure sustainability.

5 NEED TO ADDRESS CO-OCCURRING PROBLEMS

Meeting the needs of women with co-occurring disorders complicates an already complex situation. The different systems set up to deal with and address mental health and substance abuse problems are often at odds with one another. Instead of integration of care for women who have the dual problems of substance abuse and psychiatric disorders, there is fragmentation of services, and potentially conflicting recommendations.

- Efforts should be made to integrate services provided to women with co-occurring disorders in order to facilitate their ability to cope with their substance abuse and mental health difficulties.

- Women with co-occurring disorders and their families are likely even more at risk for significant mother-child problems, including removal of children from their mother's care, more volatile and unpredictable emotional climate in the home, and multiple disruptions in caregiver relationships
- Best practices for co-occurring disorders should be implemented with attention to:
 - 1) Long-term approach to recovery
 - 2) Integrated treatment
 - 3) Comprehensive focus
 - 4) Staged treatment
 - 5) Motivational intervention
 - 6) Attention to women's relationships
 - 7) Assertive outreach
 - 8) Use of cognitive-behavioral interventions.
- These components should be implemented in programs across our state through collaborative initiatives that utilize state, regional and local resources to create sustainable mechanisms that can lead to positive long-term systems change leading to better outcomes for children and families.

6 APPLY LESSONS LEARNED FROM NATIONAL AND LOCAL INITIATIVES

Because of the vast amount of information we have learned through the federal AIA initiative and local and community-based programs, we must apply that knowledge and utilize the lessons learned to develop programs in our communities that are comprehensive, sustainable, and effective.

- The following are key components of successful intervention programs for substance abuse affected families:
 - 1) Build the relationship between provider and families, as well as between caregiver and children.
 - 2) Service delivery models and approaches need to be individualized to meet the specific needs of each family.
 - 3) Multi/interdisciplinary teamwork is needed to provide optimal intervention for this population.
 - 4) Solution-focused approaches should be utilized.
 - 5) Residential projects are developed to address the needs of children and families and multiple levels.
 - 6) Comprehensive assessment is utilized.
 - 7) Care coordination/case management is implemented.
 - 8) Provide support in areas of child development, parenting support and family support.
 - 9) Work with fathers and father figures.
 - 10) Work with relative caregivers.

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