Residential Treatment for Parents and Their Children: The Village Experience

The Village South, Inc., in Miami, Florida, offers comprehensive substance abuse treatment and prevention services to adults, adolescents, and children. The Village's Families in Transition program, launched in the early 1990s as one of the Nation's first 11 federally funded programs for women wth children, has provided services to nearly 800 parents and approximately 2,000 children. This article discusses the philosophy behind FIT's family-focused residential treatment program, characterizes its participants, describes its challenges and successes, and points out research needs that have come to light through experience with mothers and children in treatment.

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Early in the 1990s, a small group of substance abuse treatment programs ventured into unknown territory. With support from the Federal Substance Abuse and Mental Health Services Administration's (SAMHSA) Center for Substance Abuse Treatment (CSAT), they began offering treatment to mothers who brought their children into residential facilities with them (SAMHSA, 2001). With more intuition than knowledge, the agencies entered the world of formulas, diapers, child-proofed living and work space, and chickenpox. They were thrown into a whirlwind transition, generally backed by little experience, research, or clinical expertise. Clinical staffs were suddenly asked to focus on such topics as parenting, pregnancy, relationships, family dynamics, and child development.

The Village, in Miami, Florida, was one of those pioneer sites. Today, our Families in Transition (FIT) program is recognized locally and nationally as a model wherein parents and children are treated in an integrated program so that as a parent recovers from illness, the multiple risks the children face—of illness, injury, school failure, emotional disturbance, and future substance abuse—are also reduced. At any given time, approximately 65 parents and 125 children live in FIT's residential facility, an enclosed campus in downtown Miami.

Over a span of 6 months or more, these families progress from a period of intense treatment and family reunification to a period of increased independence in which the parents undertake vocational training or employment, accept increased parenting responsibility, and prepare for supported reintegration into the community.

This article provides a glimpse into a residential treatment model for addicted women and their children. It reflects the experience and viewpoint of practitioners and poses questions that arise as they face the challenges of repairing the lives of families that have been damaged by substance abuse and addiction.

THE FIT APPROACH

FIT is one of a small number of programs nationwide that offer a full range of gender-sensitive, integrated services for parents, children, and other family members. FIT provides not only licensed substance abuse services, but also health and developmental services, including onsite or contracted psychological and psychiatric assessment and treatment, extended whole-family involvement, structured visitation for the parent who is not in treatment, consistent family therapy that includes children who live outside the treatment center, primary medical care, and tutoring and curriculum-based programs for children.

Because women differ from men in their substance abuse patterns, with different antecedents and consequences (Grella, 1996; Nelson-Zlupo et al., 1996), FIT addresses the issues of shame, guilt, victimization, and physical abuse that are common among addicted women. We strive to give women a sense of empowerment by providing services to meet their specific needs as well as the emotional needs of their families.

FIT operates under the central premise of family systems theory: that substance abuse and addiction help family members cope with their dysfunctional relationships, and by doing so sustain and strengthen the overall family dysfunction. Accordingly, treatment aims to rebalance and stabilize the family relationships so that substance use becomes no longer an adaptive activity, but a disruptive one. This effort entails three closely interrelated projects:

- Helping the parent become drug free, which creates a platform for change by unbalancing the dysfunctional family system;
- As the parent's recovery gets under way, helping each family member develop his or her personal strengths, acquire new skills, and gain a sense of well-being; in this way, FIT helps each family member gain stability and begin to adjust to the new family structure and learn healthier ways of relating; and
- Encouraging positive interactions among family members.

FIT also holds that the children's survival and success are just as important as the parent's recovery; and moreover, that children can recover from the trauma of their family's drug problem and go on to live healthy, productive lives, even if the parent does not recover.

Ours is a highly dynamic, even eclectic program. It would be a challenge to capture the program in a guidance manual, since several science-based approaches are utilized in different configurations, according to the treatment needs of each family. Cognitive-behavioral therapy is used extensively, as is motivational enhancement therapy (Miller and Rollnick, 1991). Elements of multidimensional family therapy also are incorporated into family treatment (Liddle et al., 2001). Both parents and children participate in group and family therapy and can receive individual psychotherapy as well. Attendance at 12-step meetings is also encouraged.

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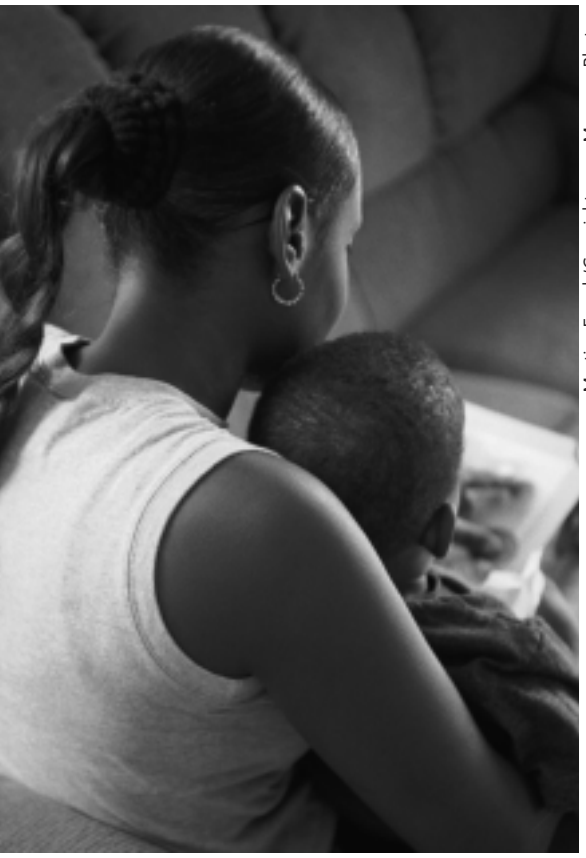
Case Management

Recognizing that substance abuse cannot be viewed as a single issue—that it entails multiple problems, all of which must be addressed to produce optimal outcomes—FIT depends upon case managers to oversee and coordinate each client's treatment. A case manager is assigned to each family, and a pediatric case manager to each child. The case manager-to-family ratio matches the therapist-to-parent ratio of 1:10.

Case-management-driven systems are not the current standard of care in most substance abuse facilities; however, we have found it an effective way to integrate the plethora of services—medical, school, psychiatric, family, vocational, and others—that are components of an integrated family approach. In this model, the therapist, rather than piloting the system, is part of a multidisciplinary team that surrounds the client and ensures service delivery and treatment for all the family's needs and ills.

Staffing and Staff Training

A well-trained staff is essential to successfully execute FIT's multifaceted, integrated approach to therapy. Our fully licensed clinical team includes a psychologist, a board-certified psychiatrist, a board-certified medical director, a doctoral-level psychometrician, and master's-level therapists. Master's-level development specialists manage children's testing and assist associate-degreed or certified childcare workers



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with providing therapeutic activities to the children. Therapists, childcare workers, behavioral health technicians, and case managers all receive specialized training that emphasizes family dynamics and reinforces their responsibility to set an example for the parents through consistent behavior toward the children.

More important than any fixed set of procedures is training of every therapist and staff member to think from a systems perspective. Everyone on staff must understand how each component of the program contributes to improving family dynamics and the success of treatment. Otherwise, the childcare professionals may focus only on taking care of the children; other therapists may focus only on substance abuse with their adult clients; and case managers may provide only referral, failing to make needed linkages among providers. Sometimes, for example, a therapist will fail to make contingency plans for children, even though there is a high likelihood that their parent will relapse and they will need to be entrusted to someone else's care. To preclude compartmentalized, counterproductive decisionmaking, we stress the need for an integrated approach in orientation sessions for new staff members, weekly staff supervision, and continuing case conferences.

Mothers may bring all their children up to age 16 with them into the FIT program, a policy that reflects our focus on family integration.

FIT MOTHERS AND THEIR CHILDREN

Profile of Mothers Entering Treatment

FIT serves an extremely diverse population, with many different cultures represented. Our residents are about 50 percent African American or Haitian, 30 percent Hispanic, and 20 percent white non-Hispanic. Mothers' ages range from 18 to 53 years, with a median age of 33. All have a DSM-IV diagnosis of substance use disorder (SUD) and meet the American Society of Addiction Medicine criteria for residential treatment. The primary drugs of abuse are cocaine, marijuana, heroin, and alcohol. Co-occurring mental health disorders are seen in about 60 percent of the women—more than the national average for individuals with SUD (SAMHSA, 2002; SAMHSA/CSAT, 2003*a*).

Of the women admitted to the FIT program, 59 percent never married, 14 percent are divorced, 9 percent separated, and 1 percent widowed. Of the married women, many have spouses who are abusive or also have a drug use problem.

Poverty is a key factor in clients' lives. Only 4 of 10 families lived independently before entering the Village. One family in four is homeless at entry; others are living in shelters or with relatives. Nearly half of the mothers have not completed high school or obtained a general equivalency diploma. Only 13 percent are employed, and another 15 percent are engaged in vocational programs.

About 85 percent of the mothers in FIT are involved in either dependency court or criminal court. Almost all are in danger of losing custody of their children. For many, FIT represents a last chance to raise their own children. As is evident in mothers' pleas as they face Miami's drug dependency judge, the need to remain attached or reattach to their children is significant. For many parents, multiple previous treatments have not kept them from spiraling back into addiction.

Profile of the Children

Mothers may bring all their children up to age 16 with them into the FIT program, a policy that reflects our focus on family integration. The mean number of children per mother in FIT has been two; we have accepted several families with six or more.

The children in the FIT program range from newborn to age 16, with a median age of 5 years. More than 50 percent have tested positive for drug exposure at birth, although over 82 percent of their mothers attempted to stop using drugs during pregnancy, most often during the second month.

The many difficulties for which children of drug abusers incur exceptional risk due to genetic, prenatal, and environmental influences include physical illness and injury, emotional disturbances, educational deficits, and behavior problems (Johnson and Leff, 1999; Metsch et al., 1995). Not surprisingly, at admission a sizeable percentage of FIT children exhibit problems: About 14 percent are already enrolled in

special education classes; 14 percent have limited English skills; nearly 30 percent have conduct problems, particularly aggression and sexual acting-out; about 20 percent have symptoms of depression. Children of substance abusers are also at particular risk of future substance-use problems (Hawkins, Catalano, and Miller, 1992). The Village FIT program strives to lessen this vulnerability by fostering parental guidance and sense of belonging, protective factors known to bolster children's ability to find alternative methods—apart from drug use—to gain pleasure and/or relieve pain (Bry et al., 1998).

Some 85 percent of Village children are clients of the Florida Department of Children and Families (DCF). The Village is one of only a few agencies nationwide that shares joint custody of resident children with the State. This arrangement provides a safety net for children should a parent decide to leave the program against advice of the staff. It also affords a strong incentive for a mother to stay in the program: If she leaves prematurely, her children must remain at the Village until DCF takes custody.

The foregoing statistics demonstrate that the Families in Transition program has undertaken a real risk in taking parents with children into treatment. We are engaging children who may have health problems or a history of neglect and abuse, and who may be at high risk of illness, injury, or emotional disturbance. We learned early in our history the importance of facing these challenges through intensive staff training and emergency preparedness (see "Gearing Up To Serve a Fragile Clientele").

HOW THE PROGRAM WORKS

Admissions Process

Each family entering FIT undergoes a comprehensive assessment that includes a structured clinical interview and a needs assessment, using standardized assessment instruments. A comprehensive service plan is developed that addresses:

- Cessation of illicit drug use and maintenance of abstinence,
- Achievement of medical and psychological well-being,
- Development of parenting skills, and
- Provision for future social and economic well-being.

The children also receive age-appropriate development and/or psychological assessments, and an individualized service plan is developed for each child.

Gearing Up To Serve a Fragile Clientele

A life-threatening episode early in FIT's history demonstrates that any substance abuse treatment program that accepts children needs to be prepared for emergencies—to undertake specific staff training and precautions at the outset to meet the children's potential medical, physical, and emotional needs.

In FIT's first year, during a "health care" group focusing on parenting of infants, the nurse-facilitator noticed a baby on a mother's lap had poor color. The child was not breathing. Fast-action resuscitation and emergency services rescued the child, who was diagnosed with viral respiratory illness. When the infant was discharged from the hospital, physicians prescribed mechanical monitoring of the child's breathing and deemed the mother fully capable of being trained in apnea monitoring and CPR, and of managing the equipment at home. The Village, the mother, and the FIT staff initially felt uneasy about taking responsibility for the infant, but it was decided that the Village FIT staff should be trained so that they could support the mother's efforts. Soon the mother was confident, proud of her accomplishments, and closer to her infant.

Teaching the Art of Being a Parent

In light of their open discussions about the care they would like to give their children and the importance they place on uniting their families, drug-abusing mothers' behavior with their children can often appear oddly apathetic. Initially, for example, FIT therapists and childcare workers naïvely imagined mothers would hover over their children in afternoon play periods, teaching them to swing or ride a tricycle. Instead, the sessions tended to become free-for-alls, with the more nurturing parents taking over the tasks for those who stared out the window or stepped out for cigarette breaks. "They are so egocentric," said a frustrated therapist. "They think bonding means being in the same room with their children, letting the children play while they visit with their peers."

Along with this lack of active teaching and bonding, FIT clients commonly expect children to learn by themselves, through observation. Researchers Johnson, Dunlap, and Maher (1998) describe an exchange that echoes many observed over the years by FIT staff: The caregiver of a 6- or 7-year-old commands, "Lock the door!" The boy fumbles with the chain locks and deadbolts. As he puzzles over what to do, the grandmother and other adults in the room, impatient and increasingly angry, begin to shout at him, calling him "Stupid," among other names. "What's wrong with you?" the grandmother says. "You've seen me do this a thousand times! Can't you learn anything?"

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The challenge for our program staff is to help women learn nurturing behaviors that will be fully congruent with their feelings and hopes.

The paper by Johnson and colleagues helped bring into focus our observations of FIT mothers' behaviors toward their children. The researchers studied conduct norms related to child-rearing in families infested with drug use, HIV infection, teen pregnancy, and poverty. The characteristics they identified include:

- No parental or other bonding given or expected,
- No expectation that parents raise their own children,
- Passing of children from caregiver to caregiver,
- Expectation that children will learn by trial and error rather than instruction, and
- Modeling and acceptance of drug-using behavior.

The paper shows that these norms evolve over generations. This suggests that many FIT clients are applying in good faith the child-rearing behaviors they know best, those that their parents used with them. To the extent this is true, there is less discrepancy between their expressed desire to unite their families and their weak nurturing.

The challenge for our program staff is to help women learn nurturing behaviors that will be fully congruent with their feelings and hopes. The FIT staff now plans all activities in the afternoon to provide mothers with insights about appropriate parenting and practice in developing their nurturing abilities. There is a focus on events and games where mothers and children talk to each other.

Structuring the family's day is essential. Several requirements and program offerings help enhance FIT clients' parenting and bonding abilities:

- Mothers are responsible for their children at all times, except during structured adult treatment groups, individual therapy, and workshops.
- Mothers and all children participate in multiple weekly workshops that help mothers assume responsibilities of primary caregivers and achieve a sense of competence in the role. These workshops include structured exercises to develop bonding and encourage positive parent-child interactions.
- Mothers must arrive at the onsite day care center 10 minutes early each day to discuss any physical or behavioral problems their children are having.
- Mothers are encouraged to spend after-dinner hours with their children, helping with homework, playing games, or using the playground. Mothers may also spend time in the childcare center, observing activities and assisting the childcare workers.
- To obtain a day or weekend pass, a parent must develop a plan that includes activities with her children. The plan is approved through a case conference, with the staff working with both adults and children.
- In collaboration with the Linda Rae Center, University of Miami, the Village offers the SAMHSA-endorsed parenting and prevention program Strengthening Families (Kumpfer, 1994) to all parents and their children up to age 3.

Prioritizing activities is a constant issue for staff and parents. Teaching and providing practice in balancing one's commitments is an essential aspect of family-focused therapy. As a mother enters recovery and gains freedom from substances, she experiences a sense of belonging that is novel and exciting. From that vantage point, she'd rather go to a meeting than stay home and care for her children. While the mother's attending four Narcotics Anonymous meetings a week may seem essential from her therapist's viewpoint, the family therapist may see it differently, taking the child's point of view. Family focus is critical in these decisions, as it is in life outside the treatment community.

Teaching self-acceptance is another important therapeutic task. Recovery entails the realization that

sometimes people make poor decisions and that it is nevertheless possible to learn to make good decisions most of the time.

FIT therapists and child development specialists have dinner with the client families three times each week. Through hands-on coaching, mothers learn how to interact with their children, from recognizing when a child needs help cutting meat on the plate to learning how to make eye contact and listen to what the child has to say. These are simple but critical interactions. Perhaps a mother learns to walk slowly to accommodate a toddler's unsteady steps instead of urging the child, "Hurry up!" as they move along the sidewalk. Gradually, the mother develops awareness of the need for and the rewards from showing consideration for the youngster, and this leads to experiencing the richness of effective nurturing.

Services for the Children

Most children entering treatment with a substance-abusing parent, even at an early age, have been harmed by the family's dysfunctional behavior. However, the families generally tend to underestimate the impact that the substance abuse problem has had on the children. The mothers may believe that their children are too young to understand or have, somehow, otherwise escaped the effects of drug abuse and dependency in the family.

While much remains to be learned about the impact of parents' substance abuse and dependence on their offspring, many studies show that harm likely begins before birth and is observable from infancy, quite often manifesting as disorganized or disoriented attachments that are quite evident even at 18 months (Espinosa et al., 2001). The older children are more deeply traumatized, entering the treatment program with a sense of shame, guilt, and fear. Most FIT children have missed many days of school in the year preceding admission. However, within a week or two, more trusting behavior, usually accompanied by more smiling faces, attests to almost immediate progress.

These children badly need attention. Symptoms include behavioral extremes—from clinging to any staff member or stranger who walks through the door, to shyness and withdrawal, exhibiting fear and distrust of their environment. Acting-out behavior is common, even at very young ages. Problems include poor social skills, hyperactivity, aggression, and anger. The children know little of boundaries; hitting and swearing are common, and the children appear to take most such behavior in stride.

One Child's Service Plan

A 9-year-old boy exhibited high levels of distractibility, fidgetiness, and outbursts of aggression. His mother complained that he was difficult to manage, could not stay on task, and at times appeared not to hear a word she said. The child care staff and school teachers corroborated the mother's observations. The child was referred for a psychiatric evaluation to establish a diagnosis and to determine the possible need for medication.

The child's problem was diagnosed as attention-deficit/hyperactivity disorder (ADHD), and Cylert (pemoline) was prescribed. A psychological evaluation provided an assessment of the child's abilities, the severity of the disorder, and his learning style. After the evaluations were completed, the FIT staff developed a service plan for both the child and the mother:

- The mother attended weekly individual education sessions to help her understand ADHD. She was educated about the need for her son's medication, what the medication was and how to administer it, and ways to promote medication adherence.
- In addition to the requirement that she attend weekly parenting workshops, the mother was provided individual parenting sessions to teach strategies for dealing with her child's behavior and to help her teach him new skills. Individual sessions also dealt with the mother's frustrations regarding the boy's behavior, her feelings of inadequacy as a parent in managing his behavior, and the relationship of these feelings to her recovery.
- The child also took part in individualized sessions, both educational and therapeutic. As with the mother, the child was educated about his diagnosis and the prescribed medication. Weekly therapeutic sessions consisted of behavioral skills training, social skills training, play therapy, and traditional talk therapy. Behavioral skills training used "stop and think" strategies to reduce impulsivity and acting-out. The play and talk therapies focused on helping the boy express his feelings about having problematic behaviors and feeling different from the other children at school.

FIT tries to meet each individual child's needs: through medication, if needed, and through therapy, including play therapy (see "One Child's Service Plan"). A family therapist is available under contract to help parents deal with children's especially difficult behaviors.

Children ages 3 to 5 attend the Village's onsite Head Start Program. Operated in collaboration with the county Head Start agency, the program includes children from the community outside the Village.

To help the children understand their families' functioning, the staff provides factual, age-appropriate information about their parents' drug problems. Starting about age 5, children meet in groups where staff members introduce the concept of addiction. The groups also teach that the children are not to blame for their parents' problems, and that the parents' behavior is caused by illness and does not mean that they do not love their children. Psychologists present these same concepts in play therapy sessions. "Strengthening Families" and other prevention curricula, including *Reconnecting Youth* (Eggert, Nicholas, and Owen, 1995) and *Preventing Bullying at School* (Britney and Title, 2001), are useful in these discussions.

Most of the older children attend grade school and middle school near the Village. The schools' proximity is beneficial, as school personnel are aware of the children's situation and can alert the FIT staff to any alarming behavior or problems that may appear. When a child has a problem, his or her parent and someone from the program staff go to the school to work out solutions.

Children's grades and behavior improve substantially while the families live at the Village. A comparison of report cards before and after entry into the program shows that grades either stabilized or improved within one grading period. Conduct reports likewise improved, and absenteeism was cut in half. Perhaps surprisingly, many children are proud to let other students and teachers know where they are living. It may be that the Village offers them a safe retreat that overshadows the fact that their mothers are there for addiction treatment.

Monitoring Progress

FIT conducts weekly "child case conferences," coordinated with the parent's case conferences, to ensure that the staff specifically addresses issues related to the children's well-being. To be sure, the children's improvement is gradual and often fragile. Severely traumatized children do not recover fully in the course of a 6-month treatment program: They need long-term attention. FIT offers several alternatives for continuing children's care after the family leaves the Village: Staff members can make in-home visits, offer to connect the family with community services in their area, or encourage family members to attend weekly group sessions.

The outcomes we look for include a higher level of understanding and performance in what is perceived as functional behavior in a family. Examples of these desired outcomes include:

- Consistent caregiving, with rules followed through;
- Consistent, reliable behavior by parents;
- The client's realization that the family can be supportive;
- The child feeling safe and trusting with the parent; and
- The family able to laugh and have fun together.

When the Outcome Is Negative

Unfortunately, while FIT's mission is family reunification, there are cases that require a family therapist to recommend to the family court judge that the children be placed in foster care or even adopted—a difficult decision made when it is evident that remaining with the parent will jeopardize the child's safety and well-being. Usually the reason is that the parent is unable to maintain abstinence. The presence of a co-occurring mental illness might also lead the therapist to recommend a change in child custody.

Pursuing an Upward Trajectory

The negative outcomes are not the usual ones, however. Overall, the FIT program has served nearly 800 mothers and 2,000 children and has a successful completion rate consistently better than those across all adult Village programs, and much better than previous Village programs targeting substance-abusing women. While our program's definition of "successful completion" has changed over the years, making precise analysis difficult, we believe that our positive outcomes are real and that they justify the effort given in family-focused programs.

However, this record of success does not change the difficulty faced by the treatment team working with parents who often were abused or neglected in

their families of origin. Although the parents have a commitment to make changes that will profoundly affect their families, including retaining custody, that desire and their love for their children do not bestow the practical ability to succeed as parents. The mothers need nurturing, and until they grow into emotional adulthood, they will continue to lose track of their children's needs and instead demonstrate inappropriate parental behavior. All staff members are challenged to keep the long-term goal in mind. When the child-mother gains a sense of the freedom of life without addiction, or when medication or behavior therapy has given her renewed hope, she begins a steady shift toward health and self-sufficiency.

RESEARCH NEEDS

The early work of individuals such as Wegschieder (1981) and Black (1987), who applied family theory to substance abuse, led to studies that focused on substance-abusing families (for example, Plotnick et al., 1998) and to work that promoted the theory of risk factors and protective factors as influences in the reunification and functionality of family members. However, there is still a scarcity of information about how recovering addicts who are parents can be helped to reduce the risk for their own offspring (Plotnick et al., 1998). FIT statistics show that the children in the program tend to improve while in the consistent treatment environment, but research on these children's long-term outcomes is needed.

CSAT's cross-site evaluation of 24 substance abuse treatment programs for pregnant and postpartum women showed striking outcomes in several areas of child well-being (SAMHSA, CSAT, 2003*b*). Notably, women who delivered their children during the course of treatment had significantly lower rates of low-birthweight babies, premature deliveries, and infant deaths than a national sample of pregnant women. But much remains to be learned about the critical elements in residential treatment that enhance family functioning while preventing or minimizing damage within recovering families.

These Women With Children (WWC) treatment programs around the country address the needs of children and other family members in varying degrees. Some operate within the traditional substance abuse treatment model, focusing primarily on the individual with the addiction problem, while offering children and families various supportive services, such as classes about addiction and its impact, babysitting, or formal daycare. Other programs allow children to join their mothers in the residential treatment setting, but do not always offer a fully integrated program for families. Research is also needed that will elucidate the differences among these programs and the outcomes that can be expected from different approaches, both in terms of substance abuse treatment (the client focus) and in terms of the opportunities they offer recovering parents and their children. Researchers should look at the following program characteristics, among others:

- Policies on the number and ages of children accepted—FIT's policy of admitting any number of children, and up to any age, distinguishes us from most WWC treatment programs nationwide, which generally permit no more than two children and only those up to 10 years old.
- Whether the mother enters treatment without her children while she "stabilizes" and has her children join her after that initial phase.
- Whether fathers, as well as mothers, are admitted to the treatment programs.

Another useful research project would be an effort to develop and test a program manual that would allow for the use of multiple therapeutic modalities—a manual for an eclectic program like FIT.

Research is also needed on the value of family-systems-based programs for fathers in treatment, and for gay and lesbian families. The FIT program is breaking new ground in this area, having expanded its program in the last few years to accept fathers. In addition, we have expanded longstanding boundaries by accepting whole families with both mother and father, or two mothers (same-sex couples addicted to substances). Some 40 to 50 married couples, 60 fathers with custody of their children, about 20 uncles and aunts, and several lesbian couples have participated in treatment.

Generally, the fathers in FIT have done well throughout treatment. Overall, the men have completed treatment in approximately 2 to 3 months, in contrast to an average of 5 to 6 months for women in residential treatment with their children. The men appear to possess a higher level of employment skills and seem to have better control of their children, but then they relapse afterward more quickly than their female counterparts. One can speculate about the reasons for their different treatment trajectories. Possibly,

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cultural prejudices, including the expectation that a man needs to assume his breadwinner role as quickly as possible, influence staff judgments. Or perhaps because the men have an easier time getting a job, the staff assumes that recovery is under way and fails to take into account the difficulties a recovering male parent will face. Research could help clarify the impact of these influences. Different measures of success may be needed for male heads of families who bring their children into treatment.

More information on the efficacy of substance abuse treatment for women is also needed. Arguably, great progress has been made; on the other hand, some would argue that a male model has been crudely adapted to women's very different situations. Issues such as a woman's relational perspective on her world, the impact of trauma and stigma, women's responses to confrontation, and the impact of motherhood on substance abuse, on treatment, and on recovery are either ignored or patched into the male model as afterthoughts.

There is also a need to study both the efficacy of and approach to treatment for the different subpopulations of women with children: Women of different ethnic groups, economic circumstances, and family backgrounds may experience treatment and recovery differently.

In addition, a nagging question faces all programs that take children into treatment with their parents: Are the services that are provided improving the outcomes of both parent and child? Research is needed on the services the children receive. We need to know whether they receive a level of therapeutic services sufficient to overcome the genetic or environmental damage that has already occurred. We also need to tease out the critical elements of integrated family treatment from the perspective of the children.

Finally, there is a need to document the costs and benefits of providing comprehensive services and implementing truly integrated family-focused services. Programs like FIT need data that will demonstrate to the public at large the value of what is being accomplished.

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Response: Treatment in Transition

Christine E. Grella, Ph.D., Carol Shapiro, M.S.W., and Dace Svikis, Ph.D.

Christine Grella: Jackson's article challenges us to rethink our entire understanding of drug treatment, expand our definition of who is in treatment, and revise our list of desired outcomes. If the family, not the individual with the drug problem, is the unit of treatment, then what counts as success must include whatever contributes to family members' well-being and the way the entire family system functions.

Carol Shapiro: I agree. I was struck by Families in Transition's ecological approach, the way it takes into account the entire context of its clients' lives. Too often, researchers and clinicians tend to isolate people, thinking about them as separate entities and ignoring their personal relationships and connections with their community.

On the other hand, I'm wondering whether the program may actually be limiting in its focus. Its emphasis on case management—on obtaining the right professional services for each child—might lead to a de-emphasis on the children's natural connections with adults other than their parents—the aunts, uncles, and godparents—who may function as their guardians. It's possible that the children's stay in a residential center will weaken or even fracture some of those connections, so that they will need to be repaired when the mother and children leave the program.

Also, residential programs like this are so expensive and the need for treatment is so staggering, that I wonder whether there are more cost-effective ways to support people where they are living. The added benefit of outpatient programs is that the transition out of treatment would be less drastic.

Grella: Actually, I felt that one of the nice features of this program was that its creators have really expanded the concept of family and make it very elastic, to include the aunts and grandmothers.

Dace Svikis: The program is definitely a significant achievement. I operated a residential and intensive outpatient program for pregnant and postpartum drug-dependent women and their children, and I remember what we went through to get our hospital to approve it, and the liability and cost issues we faced.

Grella: I like Jackson's straightforward attitude. She makes it perfectly clear that what she is attempting is fraught with logistical and other practical problems. For one thing, the presence of so many children in the program demands a major commitment of staff resources. Jackson is frank about the fact that the children exhibit serious behavior problems and that safety is a major concern. I think she should be applauded for taking on a real challenge.

Parents' needs and capabilities

Shapiro: The fact that FIT sets no absolute limit on the number of children a mother can take into treatment with her shows the author's willingness to respect the clients' real needs.