Recovering Together Program: Tailoring Treatment for Mothers with Substance Abuse Problems and Their Children

Donna Sue Spear, MA, LPC, NCAC II, and Kathryn E. Moorstein, BA

Ms. Spear is the clinical director of Clarity Counseling P.C., a treatment center in rural Colorado for substance abuse and mental health issues. She holds a master's degree in counseling psychology and is completing coursework toward a doctorate in addiction psychology. She serves on the Child Protection Team in Montezuma County, Colorado, and has written a handbook on community intervention for adolescent drug misuse in rural areas.

Ms. Moorstein is an academic advisor at Fort Lewis College in Durango, Colorado, where she earned her bachelor's degree in psychology and conducted research that included examining models of family systems therapy and developmental screenings of preschool-age children. She is also a research assistant in the college's Office of Assessment.

The primary purpose of the Recovering Together Program (RTP) is to improve child safety and treatment outcomes for mothers and the families that are affected by the mothers' substance abuse. The program measures changes in a mother's functioning, as an individual and as a parent, and predicts the likelihood of improvement. The basic strategy of the RTP is to treat the mother with substance misuse problems and the affected children. This approach minimizes the negative impact of the mother's substance use on her children, maximizes the mother's motivation for abstinence, and increases the mother's parenting skills. Current and historical trauma issues of the mother and her children are treated with sensitivity and respect. Above all, the design of the RTP takes into consideration the basic tasks of parenting and the children's needs. Women, their current partners, and their children are given tools and knowledge for rebuilding a drug- and alcohol-free lifestyle.

A proposal to develop the RTP was submitted to the Rocky Mountain Quality Improvement Center in November 2002, and the program was funded beginning in January 2003. The first cohort of this pilot program began in April 2003. Since that time, a total of six cohorts have entered this treatment program, and four of those cohorts have completed their year of treatment. (See Table 1 for size of cohorts.) The final two cohorts included in this research project are still participating at the time of this publication.

Program description

Overview

The RTP is a year-long program consisting of three phases. During Phase 1, the "initial treatment" phase, the mother and children's individual emotional and behavioral needs are the focus of treatment. Phase 1 includes enrollment in the program, intake interviews, 16 weeks of separate group therapy for the women and for their children, and attendance

at community support group meetings or recovery activities. Common community support group/recovery activities include Alcoholics Anonymous or Narcotics Anonymous meetings, support groups for victims of domestic violence or sexual abuse, classes related to concurrent legal requirements, and various religious activities. Families are also encouraged to use the local recreation center, with membership paid through RTP. Each participant develops a primary treatment plan during this phase.

In Phase 2, the "skill-building" phase, the entire family's communication and problem-solving skills are the focus of the intervention. Participants still attend community support group meetings in addition to the 12 weeks of family skill-building classes provided by RTP staff. The skill-building classes may include the woman and her children, as well as partners and extended family members. The curriculum used during this phase is a modification of the Dare To Be You (DTBY) program (Miller-Heyl, MacPhee, & Fritz, 2001). DTBY is a substance abuse prevention program that includes family training and activities for teaching self-responsibility, personal and parenting efficacy, communication and social skills, and problem-solving and decision-making skills. The DTBY program was selected based on its strong research base and the local availability of DTBY facilities and trained staff. Other prevention programs may be used for the family skill-building phase, especially programs such as Incredible Years (Webster-Stratton & Hammond, 1997), Nurturing Parents (Substance Abuse and Mental Health Services Administration, n.d.), and Celebrating Families (Quittan, 2004). Therapy services continue on an individual or family basis during the second phase, if appropriate.

Phase 3, the "lifestyle change" phase lasts approximately 6 months, or until program discharge. The mother's vocational and social needs are the focus of advocacy efforts during this final phase, which includes ongoing adjunct treatment services, as needed, and mandatory support group meetings. During this time, unmet treatment goals are modified or fulfilled, and participants engage in either employment or training for future employment.

Program staffing and location

Throughout the year-long program, families have an RTP advocate who helps them overcome barriers to success in treatment, including transportation, bureaucratic paperwork, housing, court appearances, and other systemic issues and potential obstacles. The family advocate helps by providing a supportive presence, knowledge about community resources, and assistance in reconciling conflict between the participant and persons in authority. The family advocate office is located in the treatment center, and advocate assistance is also available to participants by phone.

RTP staff includes qualified professionals in addiction and mental health. The clinical staff members working with the mothers are specialists in addiction, and the clinical director is also licensed to provide mental health services. The children's therapists are specialists in providing services to children with a variety of emotional and behavioral problems. The para-professional staff is

employed by the DTBY local prevention program and is trained in working with families to build healthier communication skills. Despite the staff's previous education and experience in family-based services, the families participating in the RTP have proven both challenging and inspiring.

In the process of providing services and developing a treatment model specific to these families, some interesting and useful information about the participants has been revealed. The staff has developed an appreciation for, and knowledge of, the pressing needs of women whose substance abuse behavior has led to concern about their children's safety and well-being. This information is based on participant families living in a rural area of southwest Colorado, but it is hoped that the information may be relevant to other areas, especially those serving the predominantly rural Rocky Mountain Region. RTP currently serves two counties in southwestern Colorado: Montezuma County (population 23,830; rural density: approximately 11 people per square mile) and Dolores County (population 1,844; frontier density: approximately 2 people per square mile). The major towns in Montezuma County are Cortez, Mancos, and Dolores. The major towns in Dolores County are Rico and Dove Creek. These communities are sparsely populated, cover a wide geographic region, and are dependent upon agriculture and tourism as major income sources. Lack of transportation within and between towns is a major barrier to human services for many individuals.

RTP admission criteria

RTP is intended for families in which there is evidence of maternal substance abuse and concern regarding child neglect or abuse. The children may be living with their mothers or in temporary alternative placement, but there must be intent to reunify the mothers with their children. Evidence of maternal substance abuse may include one or more of the following:

- positive drug/alcohol biological test results,
- recent arrests which involve substance abuse, and
- substance abuse treatment as part of a Department of Human Services case plan.

Concern regarding child neglect or abuse may include one or more of the following:

- having been involved in an investigation by Child Protection or an alternative community response in screening for child protection concerns,
- children involved and/or present during substance related arrest, or
- manufacturing of illegal substances in the children's home.

RTP intake process

After eligibility is determined, the families meet with their primary counselor or the children's counselor for three consecutive interviews. Two interviews, which involve the mother only, entail gathering data regarding her biopsychosocial history and experiences during the past 12 months. The children's intake involves interviewing the mother about each child and interviewing the children, if they are old enough. Data included in the

present document are largely derived from the mother's intake process. Table 1 illustrates the number of mothers who were referred to RTP and those who completed interviews, dropped out, or are either still participating or have completed the program.

Data collection methods

Several methods are used to collect data from participants, which are subsequently used for both treatment planning and for program evaluation. Basic demographic and substance abuse data are gathered using the Drug and Alcohol Coordinated Data System (DACODS) provided by the State of Colorado (n.d.). DACODS is a mix of client self-report and counselor ratings. Self-report data are collected using the Global Assessment of Individual Needs-Quick (GAIN-Q) (Dennis, Scott, & Funk, n.d.), which measures general factors associated with referral, sources of stress, physical health, emotional health, behavioral health, and substance-related issues. A standardized structured interview modified from the Texas Christian University intake form (Simpson & Knight, 1998) is also

Table 1. Participant intake, attrition, and completion by cohort

Cohort number	Total referrals	Interviews completed	Interviews not completed	Dropped out of program	Moved out of area	Attendance ceased due to jail sentence	Still participating or has completed program
1	9	8	1	7	*	*	1
2	9	5	4	2	*	*	3
3	11	7	2	3	*	*	4
4	6	6	*	2	*	*	4
5	24	7	6	2	4	2	4
6	19	6	2	*	1	*	5
Total	78	39	15	16	5	2	21

**Cell size is either equal to zero or data are not available*

used to collect self-report data. It includes sections on sociodemographic background, family and peer relations, and criminal involvement. Finally, biological toxicology tests upon breath and urine are used to validate self-report data regarding current drug use.

RTP family characteristics

Many of the families in RTP have a single female head of household. In fact, only 31% of the families have a male cohabitant or spouse in the home. Observation of RTP participants indicates that, although it may be unlikely that these mothers are involved in a healthy domestic partnership, they do have some level of involvement with a sexual partner. In about half of the families, the children are living with a relative or foster parent, although all of the families hope to reunite eventually. Compared with the state population, DACODS evidence suggests that RTP participants may report slightly higher rates of family issues and problems. Forty-four percent of RTP mothers report that their cohabitating partners get drunk frequently and that nearly one third of all participants in the program use drugs other than alcohol.

RTP mothers struggle to maintain steady employment and therefore struggle to achieve a steady and sufficient income. Seventy-four percent of RTP mothers did not graduate high school, and just over one half do not hold a valid driver license—two factors which potentially limit the mobility and income potential of these families. Although 40% of mothers report working full or part time in the past 6 months, at enrollment, 20% of these mothers stated that they worked less than 5 days during the previous 30 days. The remaining 60% of the mothers cite an inability to find a job, being in jail, and working irregular jobs. Even more daunting is that 26% of these participants have not applied for a single job in the past 6 months. In addition, a substantial percent (29%) of RTP women report that they have been fired or told not to return to work in the past 6 months. Additionally, nearly 60% of all RTP participants report they have had problems with transportation in the past 6 months.

Sources of income for RTP participants include their jobs, a spouse or ex-spouse, child support from a spouse or ex-spouse, a sexual partner, family members, unemployment, welfare, and prostitution and other illegal activities. A spouse or ex-spouse is cited as the most common form of income, revealing these mothers' high level of dependence on current and past sexual partners to provide for their family. Studies have shown that these partners are also likely to have substance abuse problems (Ellis & Zucker, 1997; Kendler, Davis, & Kessler, 1997), which can be a tremendous barrier to treatment success.

Since all participants have been screened by their county Department of Human Services for concerns about the children's safety, 34% have child neglect or abuse charges in the courts. Forty percent have some kind of active court involvement for drug- or alcohol-related legal problems, and almost one half are currently on probation. Sixty-three percent of the families enter RTP because of legal pressure of some kind.

Substance abuse is a concern in these families; much of the treatment for both children and parents addresses the mother's

relationship with various substances. Fifty-nine percent of RTP women report that, at some point in their lives, they have received treatment or counseling for alcohol, marijuana, or other drugs. DACODs data show that RTP participants report a higher incidence of methamphetamine as either their primary or secondary drug of choice, compared with the statewide population of mothers in treatment. State DACODS data show that participants report lower rates of using alcohol as a primary drug than those of the state population, yet they report alcohol as being more likely than the state to be a tertiary drug. Fifty-nine percent of RTP participants report that they are worried about their health or behaviors.

Although alcohol may not be reported as the primary drug for most RTP participants, they report having had more alcohol-related DUI arrests during the past 24 months than the state population. The local RTP group also reports having had more arrests other than DUIs than the state group. Table 2 illustrates characteristics of a representative RTP participant.

RTP participants report a higher incidence of methamphetamine as either their primary or secondary drug of choice, compared with the statewide population of mothers in treatment.

Co-occurring disorders in RTP women

Many mothers demonstrate a potential for "co-occurring disorders" along with any substance abuse disorders. The term "with co-occurring disorders" is used to describe individuals who have both a mental disorder and a substance use disorder (GAIN Center, 2002). Frequently, women with substance abuse or dependence have comorbid mental health disorders (Dinitto & Crisp, 2002).

In the RTP mothers' self-report, depression was the most common complaint. During intake, 57% of RTP women interviewed report that they had been previously diagnosed with depression, although only 34% had been treated for it. There were fewer reports of bipolar disorder, with only 6% being aware of a previous diagnosis of bipolar disorder and only half of those women ever being treated for it. Anxiety disorders were the second most common co-occurring complaint in the history of RTP mothers. Almost half of the women in RTP (49%) reported that they had been previously diagnosed with some type of anxiety disorder. That is substantially higher than women in the general population, of whom about 30% report problems with anxiety in their lifetime (Dinitto & Crisp, 2002). Twenty-six percent of the women had already been treated for anxiety problems. Despite the likelihood that mothers (and children) in RTP are dealing with Post Traumatic Stress Disorder (PTSD), only about one third (34%) of the women had been previously diagnosed upon RTP intake. Of those women previously diagnosed, 9% perceived they had actually received treatment for their trauma. Overall, 51% of RTP women reported having received treatment or counseling for a mental, emotional, behavioral, or psychological problem.

Table 2. Characteristics of representative RTP participant

General demographics	Children	Family characteristics	Emotional & behavioral characteristics (past 12 months)	Physical health, & substance abuse & use (past 12 months)	Criminal behavior (past 12 months)
Female	2.5 children	In past 12 months major change (marriage, divorce, etc.) in relationship	Prior mental health treatment	Prior substance abuse treatment	Arrested
30 years old	1.4 children living with her	Married once	Felt trapped, lonely, sad, depressed	Lost or gained 10 lbs	On probation or parole
Caucasian	Age range between 1 and 6 years	Supported by current or ex-spouse	Concentration and/or memory problems	Considers herself in good health	Child Protective Services taken action once
No high school diploma	Child(ren) has been removed by Child Protective Services	Both parents alive	Felt anxious and/or fearful	Sleep trouble	
Completed GED		See mother almost daily	Had obsessive thoughts	Used alcohol or drugs	
Not currently employed		Never see father	Upset when reminded of the past	Drugs caused psychological problems	
Problems with transportation in past 12 months		Natural parents separated or divorced	Difficulty expressing feelings	Used drugs despite legal risks	
		Felt loved by parents	Guilt about events that could have been prevented		
		In current contact with two family members	Difficulty staying organized		
			Insulted or swore at someone		

RTP children

It is hoped that by teaching children effective communication and emotional management skills through RTP, they will be less likely to abuse substances later in life. RTP children enter the program having already experienced life troubles, and they also need those skills for coping with the challenges of their current situation. Just about half of all mothers report to have had their children removed from their home by Child Protective Services (CPS) at some point. Reasons for removal include alcohol and drug abuse and/or arrests, domestic violence, neglect, and an overall bad environment. RTP women report having an average of three children, yet report that only about one child lives with them currently. An average of two children per mother take part in RTP. Table 3 illustrates data gathered about participating children at intake interviews with participants and their children.

The enthusiasm of RTP children within substance-abusing families who are receiving or have received services has been remarkable. After an initial period of adjustment, children begin to be comfortable in the group meetings. The staff makes a strenuous effort to create a sense of safety and an environment of openness for discussion. Sometimes, RTP is the children's first experience with openly acknowledging their mothers' substance abuse problems. As their expertise in identifying their feelings increases, along with their knowledge about chemical dependency, they embrace the opportunity to express themselves. Hope for a better future appears to soothe their fear, sadness, and anger about their family's problems, and their behavior begins to improve. In community meetings, there is a shared feeling among human service providers that these children benefit greatly from their family's participation in RTP. Certainly, the mothers report that once they become involved in the program, the children love to attend and complain when a meeting is missed.

> During intake, 57% of RTP women interviewed report that they had been previously diagnosed with depression, although only 34% had been treated for it.

Childhood history—RTP mothers' experiences

In the RTP intake interview, mothers referred to the program provided information about their own childhoods. Regarding RTP mothers' childhood experiences, 74% report that their biological parents were divorced or separated, and 42% report that their fathers never or seldom spent enough time with them while they were growing up. Forty percent report that their mothers yelled at them often or always, and 34% report the same of their fathers. Mothers in this program experienced violence in their homes as a child, with 21% reporting that their mother or father hit them hard as a child. The participant's parent who "hit them" was the mother 29% of the time and the father 40% of the time. Participants who reported that their mothers were "very strict" comprise 49% of RTP participants, and those who reported a "very strict" father totaled 37% of participants.

Table 3. Child participant intake information: Reported as counts

Cohort number	Number of participants interviewed with child(ren)	Evidence of mental health issues in child(ren)	Evidence of school attendance issues with child(ren)	Evidence of poor school grades with child(ren)	Evidence of physical health issues with child(ren)	Child(ren) showing disheveled appearance
1	2	2	1	1	1	2
2	5	5	3	3	2	*
3	7	5	1	2	3	*
4	5	4	*	1	2	*
5	6	6	3	4	1	*
6	*	*	*	*	*	*
Total	25	22	8	11	9	2

**Cell size is either equal to zero or data are not available*

Another important characteristic to consider about RTP participants is the mother's family history of alcohol and drug abuse, as well as current use within the family. In RTP mothers' families of origin, 31% of the women admitted that their own mothers or fathers (or both) either "often" or "always" got drunk. In addition, 14% of participants reported that their fathers "always" used drugs, while 11% reported that their mothers used drugs "often" or "always."

At intake, RTP participants report experiencing some negative home environments. For instance, 14% of participants had experienced the death of their mothers, and 31% reported that they seldom or never had current contact with their mothers. Forty percent had little or no current contact with their fathers, indicating that their own childhood family relationships may have been with neglecting or uninvolved parents.

Motivation for treatment

Many of the women report that they are in treatment because they want to "get my kids back" or so they can "keep my family together." Although the referral to RTP usually comes from CPS, or via the justice system then through the CPS system, the mother still must agree to attend and follow through with the referral. Families that complete the intake interview and attend sessions are motivated by their family connections. Mothers may have neglected or abused their children, but most women who participate in RTP are genuinely concerned about their children's well-being. Although conventional opinion may view female substance abusers as non-coping and lacking in effective parenting attributes, this is not always the case (Colten, 1982). Likewise, according to some RTP mothers, they do experience doubt about their parenting adequacy and they are uncomfortably aware of their children's unmet needs.

Many RTP families seem to have suffered from a lack of skills and resources rather than from an intent to harm their children. It is suspected that parents who have little or no attachment to their children are probably those who do not actively participate in the RTP; they are willing to lose parental custody or be incarcerated rather than follow through with treatment. A facet of attachment style to be queried further is how the attachment styles of the referred families relate to success in treatment.

In addition to CPS and the justice system, other informal sources of encouragement for treatment often come from relatives. Eighty percent of mothers felt that their children would be supportive of them in seeking help for their substance abuse problems. The mother's parents were also a considerable influence on their decision to get help, with almost 70% expecting that their parents would be supportive of their attempt at substance abuse treatment. Even siblings and friends seem to have influence on the mothers' efforts to get help; 60-75% of women felt that these individuals would encourage their treatment efforts. This may indicate that the majority of mothers had such substantial substance-related problems as to be noticed, and to create some level of concern by those close to them.

Although extended family members are included in the second phase of RTP (family skill-building classes), many families never make it to that point if the mother is not prepared to participate. The plight of grandparents has become especially evident in RTP when, after intake, the mother fails to attend group therapy sessions. The grandparent (who is often providing informal kinship care) may bring the children to group therapy, but children are not permitted to remain because of the lack of a parental presence. Children and grandparents often become disappointed with the mother's continued neglect and, consequently, the lack of access to the RTP resources.

In addition to grandparents, other extended family that may be involved as primary caregivers to children in this program have included the children's father, stepmothers and stepfathers, the mother's siblings, and aunts and uncles. In fact, a trend is emerging where the extended family can be viewed as one of the primary resources for these children. Because many mental health and substance abuse problems occur across generations, it is likely that whoever is caring for the children may also benefit from increased support and skill building.

Parenting issues in RTP families

Parenting issues in families that participate in RTP are very complex. The mothers of RTP children usually have a sincere desire to be good parents. However, their own families of origin modeled a variety of parenting styles, and they may lack some basic parenting skills necessary to produce healthy parenting behavior.

In community discussions, human service providers express the opinion that before these women undertake the task of examining and changing their parenting behavior, their substance abuse must be addressed. Substance misuse and abuse must be eliminated or greatly reduced. Co-occurring mental disorders must also be stabilized

before effective behavior change can begin. During the development of RTP curriculum, staff observed that focusing on parenting behavior prematurely may be counterproductive, since activating mothers' guilt and low self-efficacy interfered with emotional stability. Therefore, parenting behavior is not emphasized until the second phase of the program, the family skill-building classes using the DTBY curriculum (Miller-Heyl, MacPhee, & Fritz, 2001).

Program discussion

These participant characteristics impact treatment planning for both the mothers and the children, and given the prevalence of mothers' previous unsuccessful treatment experiences, traditional treatment methods are considered inadequate. Because of the likelihood of mothers' experiences of having either neglectful or overly demanding parents themselves, adult attachment issues, related disruptions in sense of self, and difficulty with emotional regulation are likely (Collins, 1996; Vestere, 2002). The RTP treatment curriculum assumes these attachment issues and associated challenges are present. RTP tailors treatment goals and methods to fit females with a vague sense of themselves, low self-esteem and self-efficacy, and a high degree of emotional dysregulation. Historically, traditional treatment programs initially attempt to break down denial with confrontation and a written "first step" admitting powerlessness. While this breaking down of ego and selfishness may be appropriate for treating white, middle-class males, it would be counterproductive for these participants. In contrast, RTP begins building a foundation for recovery by providing activities and topics that help each participant define herself, tell her story in a compassionate setting, and develop an understanding of self-esteem and self-efficacy.

Given the polysubstance use described by the participants, addiction treatment should target both internal experience and external behavior, rather than focus on physical dependence on any single drug. The RTP concept of addiction is based on an integrated model (Goodman, 2000) which describes a destructive relationship with drugs and alcohol rather than label participants as an addict or alcoholic. Participants learn about their emotions and certain changes in the brain that may be associated with using drugs to manage those emotions. Relapse and craving are explained based on this same integrated addiction model related to emotional dysregulation. Emotional education is the core of the RTP curriculum and is designed to treat both the addictive and mood disorders which characterize these participants. This emotional education is also indicated by participants' self-report of mood disorder symptoms, as well as their previously diagnosed and often untreated mental illness. The RTP staff refers many participants for psychotropic medication evaluation and management. The effectiveness of this concurrent medication management is complicated by common barriers, such as lack of health insurance, transportation, and financial resources. However, those participants lucky enough to have access to medical resources (usually Medicaid) report finding medication very helpful in recovery. Another benefit of coordination with

physicians is mutual awareness about high-risk pharmaceuticals, such as opiates and sedatives, which must be monitored carefully, given the tendency towards polysubstance dependence.

Due to the high likelihood of trauma problems among RTP mothers and their current partners, and their low awareness of the subject, education about interpersonal violence and the relationship between trauma and addiction is emphasized. The curriculum includes extensive information about abuse and PTSD, and clients are encouraged to access individual and family counseling to address these sensitive issues in more depth. This counseling is included at no cost to participants throughout the year-long program.

The RTP curriculum includes education and discussion about both the Medicine Wheel (White Bison, 2000) and the Twelve Steps (Alcoholics Anonymous, 1986). The inclusion of the Medicine Wheel, which may be a universal cultural concept, provides both cultural appropriateness for the Native American participants and important developmental perspective for all participants. Participants learn that the process of change is a natural progression, both in themselves and their own recovery and in their children's development. This is especially important given so many mothers' descriptions of their own parents as either absent or too strict and the tendency of maltreated children's parents to have inappropriate developmental expectations of their children (Icenhower & Tienda, 2004). The materials provided by RTP staff to participants include information on "stages of change" (Miller & Rollnick, 2002), "Ages and Stages" (Iowa State University, 2001), and information about the Medicine Wheel and the tasks and gifts of each stage of the life cycle (White Bison). In addition, education about each of the Twelve Steps is provided to bolster participation in community support groups and as a framework for understanding the recovery process. Participants are offered a choice of "big books": Alcoholics Anonymous, Narcotics Anonymous (World Service Organization, 1991), and the Red Road to Wellbriety (White Bison). To date, the Red Road book is the most popular choice among participants from all ethnic groups, supporting the staff's belief that a nature-based, cyclical understanding of the recovery process is a good fit for this treatment group's world view.

> Emotional education is the core of the RTP curriculum and is designed to treat both the addictive and mood disorders which characterize these participants.

A final example of tailoring the RTP program for these particular participants is the incentives given for attendance at RTP meetings and participation in community-based recovery activities. The DTBY program has researched the effectiveness of using incentives (Miller-Heyl, MacPhee, & Fritz, 2001), and it was initially proposed that incentives be awarded at the end of each phase. This proved ineffective with this population, perhaps because the future reward seemed too unreal for influencing current behavior. The inability to modify current behavior for distant future rewards may be

associated with attachment-related problems with object constancy. This "out of sight, out of mind" pattern has been described by human service professionals experienced with this population. Thus, tangible recovery tools (e.g., day planners, books, wallet cards) are distributed at each group meeting. These items also serve to create constancy and follow-through. The incentive structure was modified to include weekly rewards of credit at a local discount store, where the families can purchase groceries and other basic needs, such as clothing and toiletries. Attendance and recovery activity participation improved after the incorporation of weekly rewards. We expect that, when those results are analyzed, improved participation will correlate with overall treatment success.

A challenge when working with RTP children arose upon forming age-appropriate groups large enough for therapists to conduct group-oriented work. The children's program serves the children that families happen to include when they are referred to the program, regardless of the children's ages. This can create substantial diversity in age within each therapy group and difficulty in determining the appropriate developmental levels of program materials. Nevertheless, after much discussion, thought, and adjustment, a written curriculum was developed and is available for those wanting to replicate it.

As stated previously, our experience taught us that the substance abuse issues must be addressed before these mothers examine their parenting. Participants often feel ambivalence about their parenting role, as well as guilt about the past and fear about future parenting challenges. Normalizing these ambivalent feelings by open group discussion about these common experiences can be very helpful. RTP staff should engage in frank discussion among program partners and referral agencies about the importance of resolving some of these personal issues before tackling parenting issues to create cross-system understanding and agreement.

Conclusion

The population served by RTP has been found to be struggling with a multitude of problems. Those enrolled in RTP may in fact represent a skewed sample based on participant self-selection. These participants may actually represent a relatively high functioning segment of mothers with co-occurring substance abuse and child maltreatment issues. After all, these are the women who followed through on treatment referral and were able to schedule and attend a series of intake interviews. Many families were referred to RTP but did not act on the referral, and the RTP staff did not initially track unsuccessful referrals. Additionally, not all families that enrolled in the program have continued their attendance or involvement. More research is needed on treatment barriers for this population.

Another area for program strengthening is adjusting the nature and source of data regarding the children. The children's characteristics discussed here are based on somewhat subjective clinician ratings and, in some cases, entirely on the mother's description of her children. Descriptions of the children would be more accurate if information from teachers and extended family members were included in the

children's data, and the gathering of child follow-up data would also be especially helpful.

Obviously, this discussion of participant and program characteristics is incomplete, due to the preliminary nature of these data and the ongoing process of curriculum development (adjustments were made during the first year and a half of the project in response to staff perception and feedback from mothers in the program). Nevertheless, the data collected are helpful in understanding the treatment needs for other families struggling with substance abuse and child protection issues. Many of the program/treatment strategies may be helpful to caserworkerss and human service professionals who work with a similar population. In addition to guidelines and strategies for substance abuse treatment, the RTP program offers hope to frustrated human service professionals who are pressured to reunify families with seemingly intractable substance use patterns. Offering education and skill building to children, providing appropriate treatment for mothers, and achieving collaboration among community service providers may increase these families' chances for recovering together.

References

Alcoholics Anonymous. (1986) Alcoholics Anonymous (Third Edition). New York: Alcoholics Anonymous World Service, Inc.

Collins, N. L. (1996). Working models of attachment: Implications for explanation, emotion and behavior. *Journal of Personality & Social Psychology,* 71, 810-833.

Colten, M.E. (1982). Attitudes, experiences, and self-perceptions of heroin addicted mothers. *Journal of Social Issues* 38(2),77-92.

Dennis, M., Scott, C. K., Godley, M. D., & Funk, R. (n.d.). GAIN-QS. In *Research Presentations and Posters*. Retrieved Oct. 11, 2002, from Chestnut Health Systems, Bloomington, IL Web Site: http://www.chestnut.org/LI/Posters/index.html.

Dinitto, D. M., & Crisp, C. (2002). Addictions and women with major psychiatric disorders. In S.L.A. Straussner & S. Brown (Eds.), *The handbook of addiction treatment for women* (pp. 423-450). New York: Jossey-Bass.

Ellis, D. A., & Zucker, R. A. (1997). The role of family influences in development and risk. *Alcohol Health & Research World*, 21, 218-227.

GAIN Center. (2002 Spring). *Prevalence of co-occurring mental and substance abuse disorders in the criminal justice system.* Retrieved Jan. 9, 2004, from Center for Mental Health Services of the Substance Abuse and Mental Health Services Administration Web Site: http://www.gainsctr.com/pdfs/fact_sheets/gainsjailprev.pdf.

Goodman, A. (2000). Addictive disorders: An integrated understanding. The Counselor, 18, National Association of Alcoholism and Drug Abuse Counselors, Arlington, VA.

Icenhower, K., & Tienda, S. (2004, July 14). *Developing and implementing services for children within the substance abuse treatment environment.* Presentation at the meeting of the 1st National Conference on Substance Abuse, Child Welfare and the Dependency Court. Baltimore, Maryland.

Iowa State University. (2001, March). In *Ages and Stages fact sheets*. Retrieved July 28, 2005, from University Extension, Child Development Publications Web Site: http://www.extension.iastate.edu/pubs/ch.htm.

Kendler, K. S., Davis, C. G., & Kessler, R. C. (1997). The familial aggregation of common psychiatric and substance use disorders in the National Comorbidity Survey: a family history. *British Journal of Psychiatry,* 170, 541-548. Retrieved July 28, 2005, from http://bjp.rcpsych.org/cgi/content/abstract/170/6/541?maxtoshow=&HITS=10&hits=10&RESULTFORMAT=&author1=Kendler&searchid=1122616320101_6363&stored_search=&FIRSTINDEX=0&sortspec=relevance.

Miller, W. R., & Rollnick, S. (2002). *Motivational interviewing: Preparing people for change* (2nd ed., Rev.). New York: Guilford Press.

Miller-Heyl, J., MacPhee, D., & Fritz, J. J. (2001). *DARE To Be You: A systems approach to the early prevention of problem behaviors*. New York: Klewer Academic/ Plenum Publishers.

Quittan, G. A. (2004). *An evaluation of the impact of the Celebrating Families! program and Family Drug Treatment Court (FTDC) on parents receiving family reunification services*. Unpublished doctoral dissertation, College of Social Work, San Jose State University. Available at http://www.preventionpartnership.us/pdf/recent_evaluation2.pdf.

Simpson, D. D., & Knight, D. K. (1998). TCU data collection forms for women and children residential treatment. Fort Worth: Texas Christian University, Institute of Behavioral Research. [On-line]. Available at: www.ibr.tcu.edu.

State of Colorado. (n.d.) Drug and Alcohol Coordinated Data System. Denver, CO: Alcohol and Drug Abuse Division.

Substance Abuse and Mental Health Services Administration. (n.d.). *Nurturing Parenting Programs*. Retrieved July 28, 2005, from http://modelprograms.samhsa.gov/print.cfm?pkProgramid=368.

U.S. Census. (2000). *State & County QuickFacts from Population and Housing*. Retrieved Dec. 7, 2005, from U.S. Census Bureau Web Site: http://quickfacts.census.gov/qfd/states/08/08083.html.

Vestere, A. (2002). Adult romantic attachment styles and health-related measures. *Psychology, Health & Medicine*, 7, 175-181.

Webster-Stratton, C. H. & Hammond, M. (1997). Treating children with early onset conduct problems: A comparison of child and parent training programs. *Journal of Consulting and Clinical Psychology*, 65, 93-109. Retrieved July 28, 2005, from http://www.incredibleyears.com/.

White Bison, Inc. (2002). *The red road to wellbriety in the Native American way.* Colorado Springs, CO: Author.

World Service Organization (1991). *Narcotics Anonymous* (5th ed., Rev.). Van Nuys, CA: Author.