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Family-Centered Behavioral Health Support
for Pregnant & Postpartum Women

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**Perspectives on
Family-Centered Care
for Pregnant and
Postpartum Women:
Broadening the
Scope of Addiction
Treatment and
Recovery**

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Kathryn Icenhower, PhD, LCSW

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Interviews appear in this order:

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Introduction

This interview monograph offers the expertise, ideas, and inspiration of seven people who have been working hard to define, refine, and provide family-centered services to pregnant and postpartum women (PPW) with substance use disorders (SUDs). This group of researchers, educators, clinicians, policy makers, program/project administrators and directors includes:

- Karol Kaltenbach, PhD, Emeritus Professor of Pediatrics, Sidney Kimmel Medical College at Thomas Jefferson University (Philadelphia, PA) and Professor of Psychiatry and Human Behavior (retired)
- Thomas McMahan, PhD, Professor in Psychiatry and the Child Study Center, Yale University School of Medicine (New Haven, CT)
- Ruthie Dallas, BA, Project Director, Trauma-Informed Care Learning Community, Minnesota Department of Human Services (St. Paul, MN) and Women's Services Network Coordinator for the State of Minnesota
- Diana Kramer, MA, BHT, SAMHSA Program Director, Pregnant and Postpartum Women's Project, Native American Connections (Phoenix, AZ)
- Iliana Ojeda-Rivera, MA, CADC, LADC I, Director of Residential Treatment Services, Boston Public Health Commission (Boston, MA)
- Margo Spence, MS, President and CEO, First Step Home (Cincinnati, OH)
- Kathryn Icenhower, PhD, LCSW, Co-Founder and Chief Executive Officer, SHIELDS for Families (Los Angeles, CA)

This monograph is, among other things, a love story: the love of a parent for a child, the love of a true family or community for one of its own who is struggling. Added to that are the love and curiosity that found these seven people—none of whom had ever planned to work in the service of these women, children, and families—and steered them toward this small corner of the field with a strong sense of purpose, dedication, and homecoming.

In their words:

- “The State was just beginning to look at and address the needs of various underserved groups here in Minnesota, including racial and ethnic groups, and one of the underserved groups was women. As I learned more about this Division, it really held my attention. So I said, ‘Hmmm, let me go over to this area and see exactly what this is all about and what’s needed.’”—Ms. Dallas
- “In our area, when we first started this, there was no one else, to my knowledge, providing these services. They seriously would not work with pregnant women ... the clients showed up, and we’d do our best to meet their needs ... they chose our agency, and we had to do something about it.”—Ms. Spence
- “The moment a child was born and was identified as being positive for cocaine, the mothers were being detained, and usually the child was placed two or three hours away in foster care, not giving that mother any option about how she was going to get her child back. For me, that was just not acceptable, and I needed to do something about it.”—Dr. Icenhower
- “... we started a fairly large project, where we were evaluating and following the risk incurred by children living with a mother who had a drug addiction. It was during my involvement in that project, actually, that I got interested in the fact that all of the children we were seeing had fathers, and we weren’t involving the fathers in the research.”—Dr. McMahan
- “For me, it was after I started feeling a little bit more rested that I felt the constant calling to go back to doing clinical work ... so that I could really figure out for myself, was this my purpose? Was this truly my purpose? And I got the answer very clearly: Yes, it was my purpose.”—Ms. Ojeda-Rivera
- “I’ve been working for underserved, underrepresented populations for a very long time, and I’m an advocate for helping people find their voices, and allowing space for their voices be heard.”—Ms. Kramer
- “My inspiration was the women, pure and simple. They were seeking help. They had important stories to tell. They had unbelievable strength. They had been through what many of us, I think, would not have survived, and their children were important to them ... they were just an inspiration. You couldn’t walk away from them. It was extremely powerful and extremely rewarding to see them transform their lives, and you end up taking it on as a mission.”—Dr. Kaltenbach

The rest of this Introduction summarizes interviewees' thoughts on some of the major themes they explored in their conversations with their interviewer, Lonnetta M. Albright, representing the Addiction Technology Transfer Center (ATTC) Center of Excellence on Behavioral Health for Pregnant and Postpartum Women and Their Families. Themes included:

- The family-centered approach
- Meeting the children's needs
- Including and working with fathers
- The role of culture
- Challenges: trauma, stigma, and discrimination
- Focus on recovery
- Mapping the vision
- Funding and sustainability
- Strategy

THE FAMILY-CENTERED APPROACH

Not content merely to say the words “family-centered approach,” this group took on the challenge of exploring the concept and its implications, even as they acknowledged that it might take the system years to define it. The consensus is that, in PPW services, the woman sets the parameters of her true family—the nurturing, caring community where she feels supported—and those parameters can shift as each woman learns and grows into recovery.

Many women avoid treatment for fear of losing their children and leave treatment early in order to take care of their children. The field has acknowledged the primacy of relationships in many women's lives, so many of us have moved past the field's traditional attempts to insist that women simply put their recovery first. However, organizations face a number of challenges, including the need to recruit and train staff to embrace this shift, and the need to build organizational cultures in which staff members are treated like family, so they might understand how to treat clients/patients like family.

Program leaders need to think through and clarify the elements of this approach, and formulate program-specific policy statements that will help them frame the issues and questions that will arise. They will need tools, including examples of resources other programs are using (e.g., care plans, screening instruments, evaluation tools, and tracking tools). They will also need protocols, assessment tools, measures of success (e.g., the woman's level

of satisfaction with family relationships), and other resources to incorporate their family-centered approaches into practice.

Programs will also need ways of addressing legal and ethical issues that might arise as they serve multiple clients/patients at different levels of ethical responsibility (e.g., possible conflict between a woman's decision to exclude her child's father and the need to let him into the facility for court-ordered visitation).

Given the complexity of families' needs, the field will also have the challenge of gathering diverse bodies of expertise that will allow multidisciplinary teams to bring these approaches into being.

MEETING THE CHILDREN'S NEEDS

Addiction treatment programs have traditionally shied away from serving pregnant and postpartum women, and from including children in their mothers' treatment programs. Program leaders fear the liability and often lack resources for tracking requirements, setting realistic rates for childcare reimbursement, and working through partnership issues with child welfare/child protective services. One interviewee reported that a colleague had estimated that only 12 of the 4,500 opioid treatment programs nationwide offered specialized services for pregnant women.

Interviewees gave suggestions for negotiating collaborative relationships with the child welfare system ... relationships that both fulfill their legal and ethical responsibilities, as well as protect whatever processes the woman has to go through in order to reach recovery. They also recommended psychological testing for clients'/patients' children and the collection of ample developmental outcome measures.

INCLUDING AND WORKING WITH FATHERS

When the field first began to include fathers in the treatment of pregnant and postpartum women, there were some strong concerns that this move would water down the benefits of gender-specific treatment. If that concern is still prevalent, it was not reflected in the interviewees' comments.

Although none of the interviewees believed this involvement would always be safe, appropriate, and helpful—and each one pointed out reasons for assessing any potential for harm to the woman or child, and completing risk-management plans—most were enthusiastic in recommending inclusion of fathers and other co-parents or partners.

Interviewees named a number of reasons to include fathers. For example, if the relationships are ongoing, it may be more realistic to provide resources than to try to discourage the relationship. Far from watering down gender-specific treatment, said one interviewee, including fathers would expand treatment and make it more comprehensive, more sensitive to the needs of women, and possibly more effective (e.g., more productive of positive relationships and financial, emotional, and instrumental support). One interviewee offered the thought that, as long as a father's involvement was not hurting the child, it was important to address his desire to become a better father.

THE ROLE OF CULTURE

All interviewees confirmed the critical role that culture plays in the family-centered approach—described by two as “paramount.” Culture is an integral part of the individual, the family, and the community. They recommended that programs serving multicultural clientele connect with cultural guides who can lead them through the process, embed considerations of culture in all policies, and provide extensive and effective training that includes ample training in historical trauma.

Individual staff members were advised to understand their own cultural prejudices and learn whether or not they were ready and able to serve other cultures without reflecting those prejudices. It is also important not to make assumptions based on culture or cultural similarities, and instead see each person as carrying many cultural connections, with multiple influences that would be impossible to map. More tools and instruments are needed to help providers hone their cultural humility and respect, and to take full advantage of the richness of culture—including the culture of the pregnant and parenting women who are working together to seek recovery.

CHALLENGES: TRAUMA, STIGMA, AND DISCRIMINATION

In any service-provision role, it is essential to provide trauma-informed services, but associations between family and trauma make it particularly important to provide family-centered services in ways that are safe, stabilizing, and respectful. The potential for harm is too great. When partners are brought together, it is important to ensure physical and psychological safety, and to remember that men also experience trauma.

Trauma-informed approaches must be embedded in policies, procedures, and protocols. Models used must be trauma-informed and respect the need to preserve all family members' safety and stabilization, refraining from invasive

or intrusive processes. Active promotion of staff self-care can reduce the risk of vicarious traumatization and improve the staff's ability to remain appropriate, ethical, respectful, and compassionate toward the people they serve.

The stigma and discrimination often directed toward pregnant women with substance use disorders can also pose significant challenges. Lack of understanding of the protective effects of treatment medications (e.g., methadone, buprenorphine) on the pregnant woman and fetus have led to prejudice, condemnation, and poor clinical judgment that put the fetus at risk of repeated withdrawal in utero, poor prenatal care, and premature birth. Myths about treatment medications have led to shaming and rejection from the very service systems and recovery groups that instead should be welcoming and supporting these women.

FOCUS ON RECOVERY

Interviewees were enthusiastic about the benefits and importance of recovery-oriented approaches to family-centered treatment and the use of peer support services. Several interviewees confirmed the need for long-term recovery support and the value of the peer support providers connected with their programs, including staff who are embedded in all or most components of the treatment team. Clearly, the message about the chronic nature of addiction and the need for long-term support is taking hold in the field.

MAPPING THE VISION

Asked to describe the service models that would exist if they could wave their “magic wands” and transform and expand the family-centered model, interviewees painted a lovely picture. This included:

Study and Expansion of this Movement

- Powerful momentum toward family-centered treatment in the nation
- A specialized SUD treatment program for pregnant women in every city
- Significant expansion of the number of programs with specialized services for pregnant and postpartum women
- Outcome measures that are not binary (e.g., “Did she or did she not relapse?”), but instead quantify and identify gradations of success (e.g., length of abstinence, improvements in prenatal care)
- Program developers studying what is working in existing programs and gathering information about what will work in their communities

Greater Clarity Around “Family”

- A cross-system process for coming to consensus on the core definition of “family-centered approach”—a definition that individual systems and programs might enhance and interpret through their own community’s lens
- An effective system whereby women can define “family” for themselves
- A “lifespan” approach to families that does not forget about teens and elders (e.g., grandparents), who are often significant caregivers

Enhanced Services

- Trauma-informed care in all programs
- An on-site children’s therapist in each PPW program
- Stronger children’s and families’ components
- Collaboration with schools
- Expansion of prevention services
- Expansion of in-home counseling services
- Specialized services in each program location, including obstetric services, psychiatric services, case management, trauma-specific services, and parenting services
- Programs that use culture and cultural holidays, music, and food as a medium for connection, hospitality, and esteem

Workforce Development and Deployment

- An increase in opportunities for female administrators and other leaders in the field
- Extensive workforce training and development on gender-specific and family-centered care
- Many more multidisciplinary teams and strong internal and external partnerships, with particular attention to collaboration with child welfare
- Specific coordination staff (clinical or peer support) in each program (e.g., for women, families, fathers, family inclusion)

Housing and Program Location

- Housing developers who are willing to invest in safe and sober housing for families

- Half of an organization’s campus used for housing for women and families, with supportive case management
- Programs that offer women a choice between environments where only women and their children live and traditional family housing
- All services—for and from multiple systems—available under one roof, with both residential and outpatient facilities, located within the community and that are accessible to the community, with community members coming in to provide support and expertise

Funding and Sustainability

One interviewee made several suggestions in this area, including:

- Determining what needs to be done and crafting the search for funding around those needs, rather than letting the funding direct services
- Searching, not just for funds, but also for sustainability and continuity of services within the community. Making a decision not to provide services that cannot be sustained—and a commitment not to start anything that cannot continue to serve and support the community

Strategy

Interviewees provided a number of suggestions for strategy that might help one pursue a feasible and sustainable vision: Recognition of the power of data, used on people of influence, as a way of planting seeds that might grow when and if the opportunity arises

- Use of a variety of funding sources
- Strategic partnerships to bring in multi-system services (e.g., one agency partnering with hospitals, nurses, and child-protective services)
- Public education to win acceptance, backing, and support from the community
- Sheer determination

If the interviewees were neatly divided into researchers, educators, clinicians, policy makers, program/project administrators and directors, it would be easy to find a logical order for their interview transcripts. However, each of these individuals has significant breadth of experience, with many combining research, education, clinical work, policy, advocacy, and program/project direction or administration.

The interviews are arranged to follow the ideas as they pass through academia, research, policy, clinical services and advocacy—pass from what we know to the way we apply it and the things we dare to try.

- We begin our interviews with Dr. Kaltenbach, whose life-saving work with women with opioid use disorders has been foundational within the field, and Dr. McMahon, whose work with women, children, and men has brought essential questions that guide us toward a more thoughtful and humane response.
- Next, we visit the policy arena with Ms. Dallas, whose tireless work on behalf of women never seems to stop searching for better ways to bring these approaches to life in the real world.
- Finally, we hear from four individuals whose current roles involve administration of programs large and small. The breadth of their ideologies and experiences come from long and diverse careers in the field:
 - Ms. Kramer, whose varied clinical and policy experience has been arranged around a passion for culture and advocacy, continuing to take shape in her work with Native Americans;
 - Ms. Ojeda-Rivera, whose insights and ideas reflect her education, clinical experience, cultural understanding, extensive work with Latinas, and her own experience as a person in long-term recovery;
 - Ms. Spence, whose administration of a large women's treatment complex has given her a breadth of insight and ideas, plus a chance to create a safe home for women and their children up to age 12; and
 - Dr. Icenhower, whose visionary co-founding and administration of a remarkable organization in South Los Angeles currently provides 10,000 families each year with a chance for safety, healing, and recovery.

Historical Evolution of Family-Centered Care for Pregnant and Postpartum Women

An interview with Karol Kaltenbach, PhD

Conducted by Lonnetta Albright, for the ATTC CoE-PPW

INTRODUCTION

Karol Kaltenbach, PhD, is Emeritus Professor of Pediatrics at the Sidney Kimmel Medical College at Thomas Jefferson University and Professor of Psychiatry and Human Behavior (retired). She is the former Director of Maternal Addiction Treatment, Education and Research (MATER), a division of the Department of Pediatrics, Sidney Kimmel Medical College at Thomas Jefferson University. MATER includes Family Center, a comprehensive intensive outpatient treatment program for pregnant and parenting women with opioid use disorder; My Sister's Place, a long-term residential treatment program for women and children; and a research component. Dr. Kaltenbach is an internationally recognized expert in the field of maternal addiction and has published extensively on the management of opioid addiction during pregnancy and neonatal abstinence syndrome (NAS), trauma-informed treatment for pregnant and parenting women with substance use disorders, and the effects of prenatal drug exposure on the perinatal and developmental outcomes of children.

ATTC COE-PPW:

Dr. Kaltenbach, I'd like to start with some highlights or a summary of your background, wherever you'd like to start.

DR. KALTENBACH:

I've been involved in this work since 1976. I'm a developmental psychologist by training. I was getting my doctorate and doing my dissertation on mother-infant interaction in the first two days of life, so I needed a nursery with newborns. At that time in 1976, Loretta Finnegan had just moved her

program from Philadelphia General Hospital to Jefferson Medical College, and she needed a researcher to do her developmental research. The bargain was that I would have access to the nursery and I would work for her part-time, and then I would be able to conduct my own research and finish my dissertation.

Even though I finished my research and dissertation and got my PhD, I continued to work and do the research on the developmental outcome of the children that we published in the 1980s, and continued to be the Director of Research for the program. Then, in 1989, when Dr. Finnegan left Jefferson, the Department of Pediatrics wanted me to assume the administration of the program and run the clinic as well.

ATTC COE-PPW:

So, that was a treatment program that you took over, Dr. Finnegan's work?

DR. KALTENBACH:

Yes. It was family center-based. The program that Dr. Finnegan started in 1974 was a clinical program, and she was a neonatologist, so she was hospital-based. She started the program, and she received funding from the first demonstration grants when the National Institute on Drug Abuse (NIDA) was created in 1974. Heroin was a big problem in the United States due to the Vietnam War, so NIDA funded a number of programs as one of their first initiatives. These were research demonstration programs, so they all had a clinical component, and they were for pregnant women who were using heroin.

The original program—and it still has the same name today—was called Family Center. If you have a pregnant woman, you have a fetus, you have a child. So, even if the woman doesn't have any extended family, if she doesn't have a partner, if she doesn't have a husband, if she's estranged from her biological family, you have a mother-infant dyad, and that's a family. You always have a family.

Dr. Finnegan really began the model of comprehensive care. It's not what comprehensive care is today, but at that point in time, she expanded the model to include addiction treatment services, psychiatric services, and obstetrical services to meet the needs of these women. Even though a number of programs for pregnant women started in the '80s, oftentimes, you'd hear prenatal programs say, "Well, we only treat pregnant women. As soon as they deliver, then they have to go someplace else."

ATTC COE-PPW:

I see.

DR. KALTENBACH:

Her model was that that's not appropriate ... that pregnancy is a finite period of time. There's not a lot one can accomplish in pregnancy, especially when they don't come in early in gestation. To get a woman into treatment and to engage her and establish trust and be moving forward, and then, just because she delivers her child, say, "Well, we're no longer able to treat you," doesn't make sense. That is not a family approach. You have to be focused on both the mother and the infant, and how she's able to provide for her child. You want to be able to provide the services and support that are necessary so she can keep her child. From the very beginning, this was a family-centered approach.

Beth Glover Reed at the University of Michigan had a tremendous impact on our work because she was the first person who empirically began to document what we all know today as the bio-psycho-social characteristics associated with populations of pregnant and parenting women with substance use disorders. She clearly documented that they had an array of problems that went far beyond their substance use, and that these problems had to be addressed if you were going to be successful in treatment. She was one of the first people to talk about victimization and violence in the women's lives, and how that needed to be addressed.

ATTC COE-PPW:

So, this broadening of the scope of pregnant and postpartum women's services to include the family ... is this a new direction, or are we going back to continue work that was started a while ago?

DR. KALTENBACH:

I think the aim of the whole specialized gender-specific treatment has always been focused on components of family. It's always been focused on how the woman defines family, but if you look at the components of treatment, for years, we've talked about how important housing is because if the woman doesn't have any stable housing, you're not going to be able to successfully retain and engage her in treatment. All of these components—which have been labeled gender-specific—their whole purpose has been to provide a stable family unit, whether it's just the mother and child, or mother, father and child(ren), and/or the extended family.

ATTC COE-PPW:

When you talked earlier about the limitations of some programs that only looked at pregnancy, when you talked about bonding and attachment with the child or the impact of substance use on that relationship ... that was all part of what you and Dr. Finnegan were working toward?

DR. KALTENBACH:

Absolutely. And the programs that did end at pregnancy, I don't want to imply that they didn't value the woman's ongoing well-being and relationship with the baby. I think primarily it was an economic issue. They got funding for pregnant women, and they couldn't continue beyond pregnancy. We were fortunate that we had funding for a women's program. It wasn't just for pregnant women. It was created to be a program for women who would extend beyond pregnancy. I think these are economic issues in terms of funding, but not in terms of the model. We talk about that all the time today, about programs that want to withdraw women postpartum, not understanding that that's such a difficult time. Just because they delivered the baby, that's not the time to withdraw them from medication, because they are at risk for relapse because of all the stresses of postpartum parenting. We need to realize that this is a continuum. Just because the baby is born, that doesn't mean that, all of a sudden, everything's over and everything's all right.

ATTC COE-PPW:

You mentioned housing early on. That that was one of the things you understood, that housing was necessary for women to sustain their recovery and to raise their children.

DR. KALTENBACH:

That's correct. In order for their recovery to have a safe environment to raise their children, housing is just critical. We were saying that in the '80s. We always had people visiting our program. We were an anomaly because there weren't many programs like ours around. They would ask, "What's one of the most important things people need in addition to treatment?" and we would say, "Housing. If we can't get the women housing, if they can't obtain safe housing, this treatment is going to be for naught, because they won't be able to sustain recovery."

ATTC COE-PPW:

Is that program still in existence, Dr. Kaltenbach?

DR. KALTENBACH:

Our program at Jefferson? The program now has a static census of 250, so I think it's probably one of the largest, if not the largest women's program in the country, because it's only for pregnant and postpartum women. Currently it's almost 100% women with opioid use disorders. The program has two licenses: one for opioid treatment and the other for "drug-free" treatment—that's what our State calls it—so that we can admit anyone for treatment. But because of the current situation with opioid use and the fact that we specialize in treating opioid use disorders during pregnancy, our community behavioral health program refers women with opioid use disorders to us, since they have other programs that can treat women with alcohol disorders or cocaine disorders, etc. In addition to Family Center, we also have a residential treatment program.

ATTC COE-PPW:

Dr. Kaltenbach, all along, you had a family-centered approach, when many others didn't. Given that history, as you've watched our field evolve, how would you describe a family-centered approach today?

DR. KALTENBACH:

I think our approach always has been very much the way I would define it today. It's highly individualized. Focus is on the bio-psycho-social characteristics of the woman. We published a lot of work in the '90s on the bio-psycho-social characteristics and how they may affect treatment. You have to focus on the issue of violence and on the issue of trauma. You have to be responsive to that—you have to have a trauma-informed system of care. That's absolutely critical if you're going to be able to engage and support the women in treatment.

I think what's key is understanding that women define who their family is. They define who the people are who are most important to supporting them. They define their relationships, and they define their partners, whether the partner be another woman or whether the partner be a man who may or may not be the father of the baby. They define who their family is. I think that that is the most critical component. Our program has always been where

the women set the definitions. We've offered family therapy to our patients for years, but they define who the family is. They might have a mother who is willing to come into therapy and work with them, because they've had problematic relationships all their lives, and/or the mother may have had a substance use disorder also. We've had women and their mothers in family therapy; we've had women and their partners in family therapy. The woman has to define who the people are.

ATTC COE-PPW:

And you think we're losing that, even though it's stated there? That's one of the pieces that you say is critical?

DR. KALTENBACH:

I think it's critical. And this goes back to SAMHSA/CSAT's Pregnant and Postpartum Women's Summit I attended last year when everybody was divided into groups and asked how they would define family. When the group would be talking about this, if the woman defined family, it would always come back: "But the father has to be included." There are a number of issues with that position. We know that for many women, the father is still using and is a threat to her ability to maintain recovery or even achieve recovery. We know that for pregnant women, if the father is using, for example, he may try to sabotage her engagement in treatment, because it's affecting their finances, because she's no longer able to prostitute. We know there's often a tremendous amount of violence in her life. The woman may have a protective order against her partner. We know that treatment facilities have to be extremely safe places where the women feel safe. You have to focus on the issue of violence. You have to focus on the issue of trauma. You have to be responsive to that. You have to have a trauma-informed system of care.

You have to understand the context. That's why it goes back to it being critical that the woman is the one who defines who her family is. You have families that are opposed to treatment, to having a pregnant woman in treatment. They don't want the stigma and the shame of their daughter being in treatment, so they try to sabotage that.

You have families that do not understand the use of methadone or buprenorphine medication during pregnancy, and so they become very upset and try to sabotage it. All of these contexts have to be taken into account. And yes, our focus needs to be on the family, because she has to have a support system. And when you have families that have been dysfunctional,

if you can provide the services that they need in order to have a stronger relationship and be able to support each other, that's wonderful. But you have to have people who are willing to make those efforts, and not every case is the same. You can have some women who can benefit from all these services. You can have other women with whom you have to focus on her and her baby and nobody else because she has no one else.

ATTC COE-PPW:

When you talk about the context, it clears up some things for me. So, it's not just black and white—"Should fathers be involved, or not?" You're not saying fathers should not be involved at all.

DR. KALTENBACH:

No. They absolutely should, but only if there is the foundation of a supportive relationship, or working toward a supportive relationship. But you can't mandate it, and I don't think anybody intends to, but I think that's the message that comes across—that this is a requirement. And I think that's what people are pushing back against, or what they might mean when they say it's watering things down or changing the gender-specific approach. Because I think the message is out there that this is something that has to be done, and obviously it's something that's very important. The more you can help build a strong family, the better. But again, the woman has to define it. And you can't assume that because he's the father of the baby, he has a role to play in the family.

ATTC COE-PPW:

What barriers have you encountered? Some people don't understand why one would prescribe medication to treat addiction during pregnancy. Can you set the story straight on the use of addiction medications and pregnant women?

DR. KALTENBACH:

I can, but I would preface it with, as you said, "What are the barriers?" And yes, medication is a major barrier—understanding medication—but part of what plays into that is, I think, the primary barrier that we all face ... whether it comes to money, whether it comes to programs, whether it comes to attitudes, whether it is the prejudice against pregnant women who have substance use disorders, and the way they are treated with contempt—it all stems from a

moral judgment that they're failures as mothers: "How can you be pregnant and do this to your baby?"

When our clinic was in the hospital, I often had the unpleasant experience of being in the elevator at the same time as our patients and other hospital visitors. When the patients would get off, someone would turn and say, "I can't believe they just don't sterilize all those women!" The condemnation is palpable, and I think that is a major contributor to multiple barriers. It's certainly not the primary reason. People have had a problem with medication for non-pregnant patients, too. It's just magnified when you talk about pregnant patients, because, obviously, we want pregnancy to be as healthy as possible. We want to provide the healthiest environment during pregnancy, and so we try to take as little medication as possible at that time. But what many do not understand is that the medication does provide the most positive environment possible.

If you have a woman who's on the street, misusing opioids, she's going through withdrawal all the time. And every time she goes through withdrawal, her fetus goes through withdrawal, and that causes morbidity and mortality associated with opioid use during pregnancy. So often, you're going to have a premature baby who's born with all the problems concomitant to prematurity. They aren't related to the drug exposure per se, but they are related to the fact that the baby was delivered prematurely because of the mother's drug use. She's not getting prenatal care because she's actively using. So, how you provide the safest environment for the fetus is through the medication, which stabilizes the intrauterine environment so that the mother's not going through withdrawal. She's in treatment. She has to be in treatment to get the medication, so you're also able to provide the necessary obstetrical care for both a healthy mother and baby, and provide the services necessary to assist her in her recovery from opioid use.

People talk about the window of opportunity during pregnancy. I'm not quite a Pollyanna on that, because it's such a short period of time. And the women come with so many problems that it's not very realistic to expect that they're going to make a huge major turnaround in their lives in a few weeks. But it is an opportunity to get them into treatment, to get them to focus on what recovery can be, to help provide those supports, and to help address all the other unstable aspects of their lives. Moreover, they receive prenatal care, and we know that, even if the mother continues to use, prenatal care is one of the most important components of a healthy delivery.

And part of it comes from our language. We went through a period of time where people were referring to these medications as substitution therapy, or saying, "It's a substitution drug." It's not a substitution drug. It's a medication. Heroin is a drug. Methadone is an FDA-approved medication. Same for buprenorphine. Yes, it can be misused—defined as illicit use—but it's a medication.

In addition, people always focus on neonatal abstinence syndrome, or NAS. The baby may have NAS when they're born to mothers who have been receiving the medication, but people forget that the fetus goes through withdrawal when the mother goes through withdrawal, which is a common occurrence with active opioid addiction. They don't seem very concerned about that, even though that causes a lot more morbidity than NAS, which is a temporal phenomenon.

So, people often do not understand the benefits and the risks. They don't understand that NAS is treatable—and you have the media contributing to that misconception because they want to dramatize it as much as possible, so they're always showing pictures of babies in distress. So, people have to understand all of these things, which they don't. Fortunately, at least the insurers are getting a better understanding of why they need to pay for medications.

For a long time, if you had private insurance and you were on methadone, you had to pay for it yourself. Most of our women are on Medicaid because they have no income, and Medicaid has always paid for methadone. Then you have the problem with buprenorphine, where it took time to get buprenorphine into the Medicaid formula. Buprenorphine is a lot more expensive than methadone, so there are many, many barriers to this. And then you have families who literally will not support the daughter being on medication during pregnancy, because they've heard all of this stigma and all these myths, heard that she's harming her baby.

ATTC COE-PPW:

And they don't know the facts.

DR. KALTENBACH:

They don't know the facts. They need to understand that this is "a medical standard of care," going back to 1979 in a document published by the National Institute of Drug Abuse. And then we had the first state guidelines. The first SAMHSA TIP [Treatment Improvement Protocols] was the State guidelines for the use of methadone, which had a whole chapter on its use in pregnant women. In 1998, you had a National Institutes of Health consensus panel, which defined methadone as the standard of care for pregnant women with opioid use disorders.

ATTC COE-PPW:

In terms of policy, what have been some policies that have created barriers?

DR. KALTENBACH:

Let's talk about CARA [the Comprehensive Addiction and Recovery Act of 2016], talk about CAPTA [the Child Abuse Prevention and Treatment Act of 1974]. CARA and CAPTA focus on NAS, any baby going through withdrawal. CAPTA never distinguished whether the withdrawal was due to medication or whether it was due to illicit drug use, nor is it specific to opioids. The language was vague and open to interpretation.

CARA is very specific regarding actions necessary for any baby who undergoes withdrawal, yet legislators refused to differentiate between NAS as a result of a mother's being on medication and NAS as a result of her illicit drug use. So, you may have a mother in recovery, receiving medication under the supervision of a physician, who has done everything she can do to have a healthy pregnancy, is excited about this baby, and has been in a program where she's received help with parenting. And because her baby has experienced withdrawal from a medication, she has to have a safe plan developed by a social worker. She's labeled as an at-risk mother? Why?

ATTC COE-PPW:

And this is our current policy.

DR. KALTENBACH:

Yes. And what does that say about supporting a woman in treatment and in recovery, that she's going to be treated as an unfit mother if she's taking a medication? We don't do anything to a mother who has diabetes who is noncompliant during pregnancy, and so her baby has all kinds of complications.

ATTC COE-PPW:

Exactly.

DR. KALTENBACH:

Do we arrest her or say she has to have a safe plan of care? No.

ATTC COE-PPW:

Or a mother who smokes during pregnancy.

DR. KALTENBACH:

Mothers who smoke or mothers who drink alcohol and cause FAS. What do we do? Do we do anything? No. It goes back to this whole moral issue connected with the use of illegal drugs. And we're not stopping with heroin. We're talking about categorizing these women because they're under the care of a physician, taking a medication prescribed to them, and they're told they have to have a safe plan of care. Just think about that from many different levels.

ATTC COE-PPW:

As you think about policy, what advice would you give to someone considering building a family-centered program for women?

DR. KALTENBACH:

To make sure that they understand exactly what "family-centered" is going to mean to them, and how they will ensure that women are able to define the family. We talk about a woman-centered program and a trauma-informed program, where a woman will be able to participate very strongly in her treatment and in her goals, and that all goes into how you define your program. They need to make sure that this is not a top-down program ... that it's built from understanding the patients on up. (I call them patients. I know some people call them clients. But I come from a medical center, and these women have many medical issues in addition to their substance use disorders. I think it's helpful if we call them patients.)

And you need to have a commitment to what kind of staff you're going to have, and how supportive you're going to be of your staff. You need to make sure you have the right kind of staff in terms of disciplines, but you also need to make sure you have the right kind of staff in terms of their own motivation and their own empathy and capacity for compassion, providing support and not being judgmental. And you need to know your community. You need to know how your community's going to respond to your program, and if you think the community is not going to be supportive, you need to build those bridges.

ATTC COE-PPW:

Let me ask you about your research on medication and pregnant women. Do we have the research that we need?

DR. KALTENBACH:

We have years of research on that. But research must be critically evaluated. Just because it's published in a journal doesn't mean it's rigorous science, and it doesn't mean it's asking and answering the right questions. For example, in the past few years, several studies have been published in which obstetricians are withdrawing women from medication while they're pregnant in order to have a newborn that will not have NAS. These studies are focused on demonstrating that withdrawal can be done safely and produce a positive outcome, which they define as the absence of NAS. And they can answer that question in the affirmative.

The trouble is that they're asking the wrong question. We know that withdrawal from medication can be done safely. The question has always been, based on the research, why it should be done, and whether or not you should do it—because even though it can be done safely, the rate of relapse is extremely high. It's about 90%. And so you withdraw successfully, but then you have a mother relapse. What are you doing? You're putting the fetus back at risk again, so why withdraw her?

So, you have these studies that are saying, "It's safe to do so you should do it." But then, when you look at their data, there was one study where they had immediate withdrawal in women who were put into prison, and they had two deaths—two fetal deaths. And the only group that didn't have a high relapse rate was the group maintained in a hospital-based residential program, and it was a very small program that could only take a few women.

The other women, who were receiving some sort of behavioral health services but not intensive services, had a high rate of relapse. Women who couldn't get into treatment had a 70%-to-80% relapse rate. So, the work that's being done ... it's like anything: Do we have enough research? There's never enough research, but do we have good research? Yes, we do. Do we have bad research out there that's misdirecting people? Yes, we do.

ATTC COE-PPW:

So, Dr. Kaltenbach, how would you measure success of a family-centered approach?

DR. KALTENBACH:

Well, everybody always wants to focus on recovery—whether or not people are in recovery, and whether or not there's been relapse. But I don't like to use those measures because, again, we're talking about a medical issue, and relapses occur. In our program, what we always talked about in terms of success was progress over time. Is the woman really moving forward? Is she improving? And we would never put any time limit on it. It's not like the real impact of these services for this chronic illness could ever be captured adequately in 60 days. It took her whole life to get here. It's not quite the kind of thing you say you have to heal in 60 days. So, I think you have to be able to look at it very holistically. You need to look at it in terms of the percentage of women you're able to engage in treatment for the period of time that they need.

I think we need to move beyond the traditional sort of binary approach in outcome evaluation—for example, did she or did she not relapse—and instead think in terms of clarifying and measuring progress and benefit. We would be looking at the speed of return to recovery after relapse, and the amount of time spent alcohol- and drug-free between relapses. Positive outcomes should also be measured in terms of improved prenatal care, reduced prematurity, and other indicators specific to that mother—because, again, it's going to vary by individual—but looking at whether or not they've moved positively toward attaining the goals that they've set. And when you're talking about quantification, that's not always easy to do. But I think those are the more important kinds of outcomes, rather than just looking at data and saying, "How many people do you have who haven't relapsed in the last six months?" I don't think that's very helpful information. I think it's also helpful to look at staff retention, because if your program is successful, your staff members aren't going to leave.

ATTC COE-PPW:

Well, let me ask you, Dr. Kaltenbach: Is there anything else we haven't talked about that you believe is important, that we need to make sure that we communicate?

DR. KALTENBACH:

We didn't touch on funding and the need for adequate capacity to serve the women who need these programs. The fact that the PPW program has been able to be sustained for 27 years is amazing. But you're talking about—

what—20 programs on average? Twenty to 30 programs on average across the country? I'm not sure what the actual number is. The last time I counted, there were 22 or 23 programs, and we're not addressing the need at all.

When you look at opioid use disorder, there's no way of defining it, because, by regulation, opioid treatment programs have to admit pregnant women, and they have to give them first priority. But that doesn't mean they have any specialized services for them. So, when you ask whether they have specialized services for pregnant women, you can't get this out of the national database either. The fact that they say they're providing certain services, you don't know whether it's really a special service, or whether it's just a token thing. So, you really can't get any qualitative understanding of what kinds of services are provided.

But when I talked to Mark Parrino, who is the Executive Director of the American Association for the Treatment of Opioid Dependence (AATOD), I asked, "Out of all of the opioid treatment programs in the country, how many provide specialized services to pregnant women?" He said that there's no way to get that information, but followed that with, "I don't think it's more than 12." And there are 4,500 opioid treatment programs in the United States—which doesn't meet the need, which leaves one million people untreated—but only 12 programs for pregnant women. And yet we have all of this legislation directed at pregnant women, and there's no treatment for them? I mean, that's a major issue that we need to address.

It's fine to come up with these wonderful models. Just as I said, we've been doing this for 40 years, and we've been very successful at it, and people have always been amazed when they've come and visited our program. And they'd say, "Oh, but how do you afford it? We can't afford to do this. We can't afford to provide these services." And you can't, if you don't have a way of combining funding sources—getting treatment dollars, plus getting foundation support, plus getting research money that can help supplement salaries. It has to be put together with a huge patchwork of resources to maximize your funding, and that's why there are so few programs. But we certainly don't have any indication from the government that they want to provide funding to this population.

ATTC COE-PPW:

If you had a magic wand, what change would you bring about? What would it look like?

DR. KALTENBACH:

Every city would have a special program for pregnant women who have substance use disorders, a program that provides extensive specialized services—not just OB services, but also psychiatric services, case management services, trauma services, parenting services.

These programs would also have a strong liaison with child protective services, so that they work together and they're not working against each other. When the mother is constantly worried about whether or not she's going to lose her child no matter what kinds of positive effort she's making, she's in a real catch-22. Child protective services needs to make decisions based on what's best for the mother's family, and based on an accurate understanding of whether or not the child is really at risk.

Just because a woman uses substances does not mean that she's going to abuse her child, or that her child is at risk of abuse and neglect. So, we have to have a multidisciplinary approach, because, just as so many people in our field don't even understand medication for addiction treatment, certainly people in other fields don't understand it at all.

We really need many more multidisciplinary approaches, multidisciplinary teams, and collaboration between child protective services and treatment programs. Case workers in child protective services need to understand what substance use disorders are, and understand what women in treatment are trying to accomplish.

And when you can establish that kind of relationship, you can have a much more supportive and positive environment for the woman's successful recovery.

What About Fathers? Working Toward an Inclusive Vision of Family-Centered Care

An interview with Thomas McMahon, PhD

Conducted by Lonnetta Albright, for the ATTC CoE-PPW

INTRODUCTION

Thomas J. McMahon, PhD, is a Professor in Psychiatry and the Child Study Center at the Yale University School of Medicine. Dr. McMahon is interested in ways in which the principles of developmental psychopathology can be used to expand understanding of the impact that parental addiction has on family process and child development. He has worked on the development of gender-specific parent interventions for men enrolled in addiction treatment. Dr. McMahon is also interested in the psychological assessment and treatment of children, adolescents, and young adults who have been abused or neglected in the context of parental addiction, as well as clinical and research training on the roles that genetic liability and family process play in the intergenerational transmission of developmental psychopathology. Dr. McMahon completed his doctoral training in clinical child and school psychology at New York University in 1994. Since 1998, he has been the recipient of several grants from the National Institute on Drug Abuse. With his colleagues, he has published more than 75 peer-reviewed papers and book chapters.

ATTC COE-PPW:

Would you please highlight or summarize your background prior to your current role at Yale, and give us a sense of who you are and what brings you into this work?

DR. MCMAHON:

For a number of years, I worked on an inpatient psychiatric and addiction treatment unit that served people who were over the age of 14. While I was there, I got interested in two things. I got interested in the younger clients and did a lot of work with the adolescents who were admitted to the hospital. It was a combined adolescent and adult unit.

I also got interested in methadone maintenance. There was an outpatient methadone maintenance program in the psychiatric division where I was working. So I did that for quite a while and actually went to graduate school a little bit later than many other people. After that, I got my doctoral degree in clinical child and school psychology.

As part of my doctoral psychology program, I did an internship on an adolescent psychiatric unit, where many of the kids were involved with child protective services, often because of parental substance use. The hospital had an emergency evaluation unit for children who had been removed from the care of their parents on an emergency basis and needed a comprehensive evaluation to help the child welfare system make plans for placement and treatment.

When I finished my internship, I came to Yale and began to work with an addiction research team that was generally interested in family issues, the impact of substance use on family life. The first project I was involved in actually was one of the precursors or early PPW programs for pregnant and parenting women who needed access to methadone maintenance treatment.

We were doing the evaluation for an outpatient program, but I also began a project working with the women in the program about concerns they had for their children. We began a project to try to put more family-friendly or family-oriented services inside this methadone maintenance program. Among other things, the program had a daycare center or a childcare center.

There was a childcare room where, as long as the mothers were on-site for treatment, their children could be in the childcare room while mothers were in group, or seeing their clinician, or seeing a physician for medical reviews. While I was there, I began to just field the questions that women had about their children. A lot of them were questions about normative child development, but also a lot of them were questions that came out of their concerns about their child's well-being, their child's exposure to some of the things that we know children living with parents who have addictions are exposed to.

ATTC COE-PPW:

You were working in one of the first pregnant and parenting programs at Yale?

DR. MCMAHON:

Yes. This was a CSAT-funded program, one of the early efforts to develop gender-sensitive programming for women. It was probably 1992 or 1993.

ATTC COE-PPW:

Was your childcare component unique during that time?

DR. MCMAHON:

I think it was unique in an outpatient setting. As they developed a program, at least in this state, they established that, as long as the parents were not leaving the grounds, they didn't have to be a licensed daycare center. They had to meet some basic requirements for safety and expertise for working with children, and they actually had a preschool teacher who ran it with an assistant.

They were able to offer the service to support mothers being in outpatient treatment, basically by having someone available to watch their children and engage them while the mothers were getting whatever services they needed.

Sometimes it would be as brief as 20 minutes, so that women could see a counselor or a nurse, get medication, and then come back and pick up the child, and be on their way. Sometimes it was longer, for the parent to be in a series of groups or to meet with a series of people for half a day.

ATTC COE-PPW:

So, you started out with an interest in working with children?

DR. MCMAHON:

Yes. I was part of a research team that was interested in the risk that children living in poverty incur. With funding from the National Institute on Drug Abuse, we started a fairly large project, where we were evaluating and following the risk incurred by children living with a mother who had a drug addiction. It was during my involvement in that project, actually, that I got interested in the fact that all of the children we were seeing had fathers, and we weren't involving the fathers in the research.

ATTC COE-PPW:

Would you share your perspective on how gender-specific services for pregnant and postpartum women evolved?

DR. MCMAHON:

I think there had been some earlier work done by some people whose names I'm not remembering ... although one of them was certainly Karol Kaltenbach, who had done a lot of work with women in methadone maintenance. But it was the beginning of people taking seriously the fact that addiction treatment needed to be different for women, and that there were some services that women needed that were not readily available in most addiction treatment programs, because the women were a minority presence. They were outnumbered at least two to one in most programs.

I think along the way, though, I realized with some other people I was working with—and I think it's still true to some extent—that the addiction treatment system is actually a pretty gendered place.

If you're female, you're supposed to take care of your depression, and your anxiety, and your trauma, and your children, and you're supposed to stay away from these men who are no good for you. There is less of an emphasis on work and other issues. If you're male, you're supposed to see your probation officer, get a job, and stay out of trouble. It certainly was our impression that there really wasn't a lot of acknowledgement that many of these issues are important or critical for both men and women.

I think there should be an emphasis on other issues relevant to parenting, work, and financial support. Many women would come to treatment after they had already lost custody of their children. Many would come after they got involved with child protective services. But I think we acknowledged that women were more likely to come with children in their care, and that did mean there were things they needed support around.

But at the same time, I think that fact created the idea that there were really no men who were parents in addiction treatment, and that there were no men with trauma symptoms. There were no women who might want vocational rehabilitation. There were no women who might be in trouble with the law and need to do something for probation. I may be overstating it, but I think that, years ago, a lot of these attitudes were pervasive within the addiction community, including the addiction research community.

ATTC COE-PPW:

How would you say the research has moved us along?

DR. MCMAHON:

I think, in some ways, we've come full circle. Early on, there were as many efforts to develop outpatient programming for women as there were efforts to develop residential programming. It seems like, in the middle of this process, there was more of a focus on the residential. And now, people have come full circle and have begun to talk again about what gender-specific outpatient or intensive outpatient programming should look like today.

I think ideally we need a continuum of services that address the needs of women in different ways depending on their type of addiction and their family situation, and their ability to establish abstinence. In the midst of the opioid epidemic, the use of addiction medications in outpatient treatment may be very realistic. We may not have to admit women to residential programs.

Another factor to consider when talking about PPW programs is that there are limits or costs for the children when you admit them to a residential program with their mothers. It takes them out of their community, assuming they're not in the same community or same neighborhood when they enter treatment with their mother. It takes children away from other community resources and other family resources that may be available to them.

ATTC COE-PPW:

As we've broadened the scope of women's recovery and wellness to include the family and, in particular, fathers, some people feel that we're watering down gender-specific approaches to care. How would you answer that concern?

DR. MCMAHON:

I understand why it is a concern, and I also think, in terms of developing a holistic model for treating women, we have to acknowledge that most women, or a high percentage of women, entering treatment are either involved in or have a history of being involved in sexual partnerships involving men. Anyone who is a mother entering treatment has a father or more than one father of her children somewhere. If you're going to develop a holistic approach to treating women, you have to acknowledge the role of men in their lives.

I don't see it as watering treatment down. I see it as expanding treatment and making it more comprehensive, making it even more sensitive to the needs of women, and possibly even making it more effective. Because over the years working with both men and women who are in treatment as parents, we've seen the complications that evolve in these relationships. Women do not end difficult relationships with the men in their lives as often as addiction counselors might believe they should or recommend they should.

For me, the first question is more how to help a woman who wants to continue the relationship in a safer way. Then, how to continue it in a healthier, satisfying way that may actually improve things for mother, father, and child. That was one of the themes I emphasize that women—if they can have more productive or positive relationships with the father of their children—they stand to benefit in terms of more financial support, more emotional support, and more instrumental support.

Again, I understand the concern. I understand where it evolves from historically. But I think to take the next step in terms of developing comprehensive programming, you cannot ignore the fact that a high percentage of the women seeking treatment are heterosexual. They have children. Their children have fathers, and many of the women have ongoing contact with the fathers of their children. Many of the relationship issues among heterosexual couples are also issues within lesbian couples. So, I think part of taking the next step in developing or expanding the model is to consider what can be done to improve the marital, partner, and co-parenting relationships of women in treatment.

ATTC COE-PPW:

When you talk about involving the family, what's your experience around the woman's role as the one with the responsibility and the right to decide who the family is?

DR. MCMAHON:

I think this is an issue that programs have to think through. I think that if the mother is your client, then the mother has the right to determine how she defines family for herself and who participates in her treatment. I think it gets trickier, though, when you're talking about the same issues for the child, because generally the child protective system, family court system, the divorce court system ... does not allow mothers to define family for the child unless she is the sole custodial parent. There are limits to people's ability, or mothers'

ability to define family for a child, especially when it comes to the child's relationship with his or her father.

I think it's tricky because the mother is defining family for herself, but it could be that her definition for herself could be at odds with other definitions that people may have for the child. For me, that is an ethical/legal issue that the programs are going to have consider with their clients and help their clients negotiate.

In one of the curriculum modules I helped develop for the ATTC CoE-PPW, we outlined some considerations for programs to think about when developing this portion of their treatment program. For many programs, the first step may be for them to think about some of these issues and to clarify where they stand as a program, particularly if they have children in the program.

Programs may need to develop a policy statement that outlines the thinking about family involvement. We had to do that. Honestly, when we started working with the men as parents, we did that for ourselves, because a lot of people were skeptical. We were somewhat skeptical, and we found it was really helpful to actually put on paper what our thoughts were about why we were trying to promote men's involvement with their children.

ATTC COE-PPW:

How easy or difficult was it to gather those thoughts on policy as a group and speak to the mission and the values of the organization?

DR. MCMAHON:

I think, if you have to put it on paper and get consensus, it forces people to think it through and invites a discussion about different points of view. It's a necessary first step. Otherwise, I think that the program could have difficulty later on. It provides a framework to address questions when they come up. We had a similar concern, but we actually wrote that we were doing this first for the men because the men were our clients. If they wanted to be a better father—if they wanted help being a better father—then unless they were doing something harmful or there was a court order saying they couldn't be involved with their child, we had an obligation to help them as best we could.

It was helpful to frame it that we really were not doing it primarily for the child. If it was a benefit to the child, that would be great, and we expect that there would be benefit for the child. But as long as there was no harm for the child, we agreed that we had an obligation to listen to the men who said they wanted to be better parents.

I think one of the things of note—and again, this goes back to the ideas about gender and parenting—is the idea that we don't question whether or not it is good for mothers to be better mothers. You rarely hear someone say, "I don't think she should get her children back," or, "I don't think we should help her try to be a better mother."

ATTC COE-PPW:

Are you saying we don't hear the same thing when it comes to men?

DR. MCMAHON:

Generally not. I think it is a complicated issue. I think that there is a way that mothers have a right to define their family for themselves. At the same time, there is a lot of evidence and legal and ethical arguments that say the mother does not have the exclusive right to define family for the child.

ATTC COE-PPW:

Would you describe the distinction between treatment and recovery from your perspective?

DR. MCMAHON:

For me, I think that treatment is more about addressing problems, particularly health problems or behavioral health problems. It's primarily about addressing the substance use. I think, over many years, we have learned that abstinence is not recovery and, in some ways, getting people abstinent may be the easier part of the process in the short term.

Recovery moves beyond just addressing health and behavioral health problems—addressing symptoms—to thinking about promoting development. I was trained and think as a developmentally oriented clinician, and recovery is about promoting people's development as adults.

ATTC COE-PPW:

From your perspective as a researcher, what would you say we know now about a family-centered approach?

DR. MCMAHON:

I think we know that family is an important influence, an important concern of clients in addiction treatment. I think we have a reasonably good understanding of the family problems that people bring to treatment. I think we have varying degrees of information about different dimensions of family life for our clients. I think we know a lot about things like the relationship between substance use and intimate partner violence, for instance. We have a growing and pretty substantial database about the risks of substance use during pregnancy. I think there are some other areas where we don't have as much of an understanding.

I don't think we have a lot of information about couples. For example, information about ways that couples negotiate or co-parent when one or both partners are using. How they negotiate the substance use of one partner, or how they negotiate parenting when both parties are using. I obviously don't think we have much of an understanding about men's perspectives on family issues, particularly as parents. It has always troubled me is that I don't know that we have a good understanding of how children understand the substance use of their parents. As adults or as a culture, we don't have a consensus about what substance use represents.

I don't think we have a good understanding of ways that children who are affected by their parents' substance use understand the problem, what they think about it, how they understand it.

There are a lot of questions about intervention that haven't been answered, or about types of interventions. We could use a lot more information about intervention.

We don't know much about the effectiveness of many family interventions. We know something about things like Behavioral Couples Therapy and Community Reinforcement and Family Training, or CRAFT. We know something about how to help families get a family member to treatment. We don't have good answers about how to address the intimate partner violence. Generally, I think the efforts that have been made to address it have been somewhat disappointing.

ATTC COE-PPW:

What are one or two of the most significant obstacles to moving from the traditional dyad—provider to the woman as the client/patient—expanding from that to include children and particularly fathers?

DR. MCMAHON:

I think one is assembling the expertise that you need under one roof. From what I understand, some of the PPW programs have done this, but I think there's a challenge in expanding the expertise and developing partnerships or teams that include the expertise you need to deal with, not only the addiction issues, but also some of the parenting issues, some of the marital issues, some of the child development issues.

I don't think it works to send parents across town, because many of them have a hard time getting to the addiction treatment program. The expertise should be available where you get your addiction treatment. But I think there's a challenge in developing the expertise and bringing together teams that have different expertise. There are going to be some challenges around dealing with some of the legal and ethical issues, because you have multiple clients, or you have people involved in treatment who you may have different degrees of ethical responsibility to, with the mother being the identified client and people offering some services to the child and services to other members of her family. So I think that's inevitable. It's going to raise some legal and ethical considerations.

ATTC COE-PPW:

Any other obstacles stand out for you in this expansion to this family-centered approach?

DR. MCMAHON:

There are risk-management challenges. It's relatively easier to keep people safe when they're in a residential program and there is minimal participation by partners and other family members. But if there is more development of outpatient programs and women are living in the community with their children and their partners, then I think there are challenges keeping people safe in the program, and there are challenges keeping people safe in the community.

ATTC COE-PPW:

How would you measure success of a family-centered approach?

DR. MCMAHON:

I think by women's satisfaction with their family relationships, with their extended family, with their partners, and with their children. I think the quality of their relationships with whoever their co-parents are, whether it is their mother, or their sister, or the child's father. Obviously, the quality of parenting by everyone involved is also an important outcome for everyone involved.

ATTC COE-PPW:

What is your vision as we move toward more inclusive family-centered care?

DR. MCMAHON:

I think, ideally—and I know it's easier in urban settings—the program would be community-based. It wouldn't remove women from their community. It would be accessible from their community, and people from the community might be brought in to support the program or to provide expertise. In my opinion, the thing that I think really undermines people's treatment is when they get sent all over town. They have to go to social services for benefits. They have to go one place for their primary medical care, another for their OB-GYN care. They have to go somewhere else for their children to be seen.

They also have to go to school for their children, or they have to go to daycare for their children. If you look, sometimes, at the number of providers that some of these families have, it's overwhelming when you're a provider. I cannot imagine what it's like to be a parent or a couple struggling with addiction and mental health difficulties. And I don't think one agency needs to provide it all. But rather than sending the client to all these places, to bring these places to the client. Because the one place we want people to consistently go is for addiction treatment. Otherwise, I mean, if people relapse, the risk is that the whole thing comes undone. So, for me, to bring what the client needs to the addiction treatment system makes more sense than sending them all over.

Policy Perspectives on Family-Centered Care

An interview with Ruthie M. Dallas, BA

Conducted by Lonnetta Albright, for the ATTC CoE-PPW

INTRODUCTION

Ruthie M. Dallas, BA, is the Project Director of the Minnesota Department of Human Services Trauma-Informed Care Learning Community and the Women's Services Lead Planner for the DHS Alcohol and Drug Abuse Division, located in St. Paul, Minnesota. She also serves as SAMHSA/CSAT's designated Women's Services Coordinator for Minnesota and is a member of the National Association of State Alcohol/Drug Abuse Directors Women Services Network and a graduate of SAMHSA Women's Addiction Services Leadership Institute and Minnesota DHS Leadership Program. Ms. Dallas has worked for the Minnesota Department of Human Services for 37 years. She specializes in women's services, racial and health disparities, and trauma-informed care, managing grant contracts in excess of \$5 million.

ATTC COE-PPW:

What drew you into this work?

MS. DALLAS:

I think I've always had a passion for social justice and really addressing the needs of underserved and vulnerable populations. When I came into the Minnesota Department of Human Services, the State was just beginning to address the needs of various underserved groups in Minnesota, including racial and ethnic groups, and one of the underserved groups was women. And as I learned more about this division, it really held my attention. I started out trying to address the needs of women of color, and it soon became clear that the needs of this group were even more critical than the needs of women overall.

ATTC COE-PPW:

From a state and federal policy standpoint, how would you describe the current evolution of women's treatment?

MS. DALLAS:

We're moving toward having trauma-informed care incorporated more into our policy and our licensed treatment facilities and programs. In the past, most programs were dealing with the clinical aspects of trauma with the client directly. Now, there is more of a demand to start looking at creating trauma-informed care environments, as well as providing trauma-responsive and trauma-specific services. This entails looking at the staffing self-care—making sure they're taking care of themselves. Dealing with the lack of self-care is an important part of addressing trauma and its effects—both for the client and within the organization.

We're starting to look at how we can collaborate and bring all of these different systems together, because we are all addressing trauma in certain ways. We are in the process of expanding and bringing all of the behavioral health providers together to address this issue of trauma-informed care.

It should be a common thread in everything we do—policy, procedure and practice. In some ways similar to recovery-oriented systems of care, trauma-informed care should be thought of as providing an overarching framework for our model and continuum of care.

ATTC COE-PPW:

How has gender-specific programming evolved in your state?

MS. DALLAS:

I think it has come a long way. A number of years ago SAMHSA issued a Treatment Improvement Protocol (TIP) 51: Substance Abuse Treatment: Addressing the Specific Needs of Women. We're now able to get information out there that can help practitioners know specifically what to do, and what the best practices are in working with women who have substance use disorders.

We have so much work to do with pregnant and postpartum women. A critical part of their care is the relationship with their family. You need to deal with the fathers or the significant others in that setting, for her to be well and whole again. So, that's why a lot of relapses occur, and women come right back into treatment because they just haven't dealt with that part of it.

They're going to return to that home in the community, but nothing has been done with that piece of it, for them to feel whole and well.

ATTC COE-PPW:

Now, from a State and policy standpoint, what have been some of the challenges in doing things differently?

MS. DALLAS:

We've had challenges around including the fathers in the family-centered processes connected with our women-specific programs. It has been difficult, but it's gradually happening. We have to look at the philosophies of the women's service providers who are serving the client, and see how receptive they are to including men.

Then we have to address the whole thinking of providers around bringing children into treatment; a number of adult programs don't want the liability. This is even more of an obstacle to having pregnant women come into their programs.

Housing is an issue. Is there some way we can bill housing into the overall benefit? Could we set rates so that the benefit would cover housing as well as the overall treatment services, as part of benefits covered? Are there private housing developers who are interested in investing in sober housing for pregnant and parenting women? It would help tremendously.

Where do women go once they complete the programs? It's going to be essential to get our policy makers to look at the need for long-term support. A chronic illness is a chronic illness. People need continuous checkups, as opposed to going through treatment once or twice and that's it—that should do it—you know? Very often, that doesn't do it.

ATTC COE-PPW:

How would you, from the standpoint of policy and funding—and as WSN and Trauma-Informed Care Coordinator—how would you work within a family-centered approach?

MS. DALLAS:

We have to look at it from the family perspective. Right now, the policy is set up for the individual client, with individual care plans. But in a family-centered approach, we would look at several plans, covering all those family

members. And even though we have to refer clients out for certain services—especially services for family members—they have to track what happens to each family member. Our grantees are now required to tell us what their tracking plans will be and what mechanisms they would use to know what’s happening to that family member.

We have to look at the various screens needed to determine what kind of help all family members need. We have a comprehensive assessment, and our treatment providers use it now. But I think we would have to make changes in that overall measure of effectiveness, to make sure we’re including the family members.

Aspects of care, like housing and employment supports, can be great motivators for the women and really get them engaged. Providers need the dollars to pay for childcare and transportation for the woman and for family members, too. How do we make it happen? We need to look at policy, to see how those things can happen. And we need a model design for a family-centered approach. Providers need training on this approach and know what best practice would look like.

ATTC COE-PPW:

How would you develop your workforce?

MS. DALLAS:

I think we’d need to come up with some creative ways of doing workforce development and training skilled workers, because all of these things cannot happen unless we have the workers who can do it. There’s a shortage now ... a shortage everywhere. We can create this family-centered approach. But where are the workers we need?

We are very much at the place where we need to build or create an ongoing training development system. So many things are moving so quickly, and the providers and systems are not getting the information they need to prepare their staff for these changes.

ATTC COE-PPW:

Where do you think providers stand in terms of including fathers/partners in treatment – do they think this approach is watering down gender-specific treatment?

MS. DALLAS:

No, I don’t think so. But it could appear that way to some of the providers who have been out there in this long struggle for gender-specific programming. I think we now have to look at how to write this into policy, and have the funding to go with it, because family-centered care—who pays for it? Even our SAMHSA funds are geared toward pregnant/postpartum women. So we have to get the funding sources to start adjusting and saying, “Okay, let’s look at the entire family.”

And one thing I was going to mention about our State movement in this area is our accomplishment in setting enhanced treatment rates. We now have a rate that deals with clients with children, and this was not in place several years ago. We keep advocating for more dollars that go toward enhanced care. We want adequate funding provided for quality childcare.

ATTC COE-PPW:

How would you describe the distinction between treatment and recovery, and what are some of the implications for women’s recovery services?

MS. DALLAS:

Minnesota is going through a transformation in its systems of care. Treatment has always been pretty much based on an acute-care model. As we move toward a focus on recovery, recovery support opens up the door for a number of women because we still have pregnant women who refuse to go into treatment. Addressing recovery is key. There are many pathways to recovery. If we get so caught up in, “This is the only way that they can be well, by going into a treatment program,” then we’ve really lost that person. And we’re still losing quite a few because of that.

The woman may be refusing treatment because she’s afraid of losing her children, but if she’s pregnant and refusing treatment, we can get into a mandatory reporting situation, and that could lead to the loss of her children. So, the stigma is still there, and the fear is still there.

ATTC COE-PPW:

Can you speak more about Minnesota policy around women in recovery?

MS. DALLAS:

We're working with child welfare. The Minnesota Department of Human Services released a guide, Minnesota's Best Practice Guide for Responding to Prenatal Exposure to Substance Use, which looks at the woman in recovery in a more positive sense. So, we really have to look at what the options are for women, as opposed to focusing on mandatory reporting and that's it. We need to be able to give assurance to women, that they can get help and not lose their kids.

ATTC COE-PPW:

How might you measure the success of a family-centered approach?

MS. DALLAS:

We'll look at whether there was actually a care plan—a treatment plan—set up for the other members of the family. We'll promote the use of best practices. SAMHSA requires us to track what's happening with other members of the family, what kinds of services were provided, how accessible they were, etc.

A good tracking system is important, if providers are referring family members to certain services their organization can't provide. How good is the tracking system they're using? Do they offer a comprehensive assessment and plan for the total family?

ATTC COE-PPW:

Is the opioid crisis having any implications for services for women and their families?

MS. DALLAS:

Alcohol is still Minnesota's number-one drug used overall. But heroin use has surpassed alcohol use for Native American women. On the reservations, and within the city, it's like an epidemic. The tribes need a lot of technical assistance to make services for the care of babies and moms more accessible. Many Native American women are losing their kids to foster care. The White Earth MOMS Program has been very successful because of their approach to family-centered programming. They're including the father, as well as the mother and children.

ATTC COE-PPW:

When you think about culture, how important is that in a family-centered approach?

MS. DALLAS:

If we truly want to address culture in our services, we need to embed culture throughout all of our policies. It should be an overriding factor in whatever we do. I know, a number of programs are happy to adapt existing curricula. A number of our Native American programs are beginning to adapt their training and curricula by incorporating input from their spiritual leaders and healers.

We've also been doing a lot of historical trauma training, and that's been very helpful in getting providers on this path. We've been working with the whole history—what the trauma was like—and talking about healing traditions in Native American cultures.

We also have a large and diverse immigrant and refugee population in Minnesota. Whenever you've got refugee communities, you've got trauma and, sometimes, historical trauma. After the Vietnam War, Hmong people immigrated from Laos. Trauma has long-term effects.

As policy makers, we have to really reject discrimination, even if it's just unintentional exclusion because we didn't take the time needed for the process. If we want to truly incorporate culture, we need everybody at the table so there can be a truly inclusive dialogue. It shouldn't be just us deciding as we're developing these policies.

ATTC COE-PPW:

If you had a magic wand, what change would you bring about? What would it look like?

MS. DALLAS:

I think we need to keep looking at the total picture: Who is family? How does the woman define family? I think we need to be open enough in defining a family-centered approach. What does that mean? Some people tend to think of the primary family—mother, father, children, or whatever. It might not be that for some women. Policy makers need to be open enough—to accept family may be defined differently as we lay out a solution for providing family-centered care.

We also need to take a “whole-lifespan perspective.” When we say “family-centered approach,” we’re looking at specific members of the family—the woman, the children, the father—but I think we also have to make sure we don’t forget the needs of members of the family who are often overlooked, such as adolescents and older adults—particularly the older women ... the grandmothers. How do they fit in? A lot of grandparents are taking care of these babies whose parents have substance use disorders. I think, when we say, “family-centered approach,” we have to be sensitive and open to allowing grandparents to be involved. So not to forget about that, and to look at the lifespan that goes into the family-centered approach.

I would like to see more female leaders in the field of substance use disorders. We don’t have enough women who are administrators of these gender-specific programs and family-centered services.

If we don’t have the right leadership, it will affect this whole movement toward family-centered services for pregnant, parenting, and postpartum women. We need to have the right people in leadership roles thinking through this. We need women from the community helping to shape policy.

The Importance of Culture in Family-Centered Care

An interview with Diana Kramer, MA, BHT
Conducted by Lonnetta Albright, for the ATTC CoE-PPW

INTRODUCTION

Diana Kramer is SAMHSA Program Director for the Pregnant and Postpartum Women’s Project at Native American Connections in Phoenix, AZ. Ms. Kramer’s focus is on improving the lives of individuals, children, and families, with an emphasis on Native American traditional healing, wellness practices, and the delivery of culturally adaptive comprehensive residential treatment services. As Cultural Competency and Workforce Development Manager for the Arizona Department of Health Services/Division of Behavioral Health Services, Ms. Kramer provided support and oversight of system-wide and region-specific initiatives, program enhancement, policymaking, contract management, training, and workforce development for the purposes of ensuring culturally and linguistically appropriate services for individuals accessing behavioral health services across the state of Arizona.

ATTC COE-PPW:

What brought you to work in a PPW program?

MS. KRAMER:

I began my career at a provider called Chicanos Por La Causa. From there, I went to the State of Arizona and worked within the Arizona Department of Health Services/Division of Behavioral Health. I was there a long enough time to see behind the scenes—working from a policy- and State-level perspective—how policy changes from federal initiatives directly impact State systems, how those changes affect providers or agencies, and ultimately, their impact on communities and individuals who are accessing or receiving services.

I now oversee the SAMHSA grant for pregnant and postpartum women at Native American Connections (NAC) in Phoenix, AZ. NAC has a wide variety of services and support they provide to tribal and non-tribal individuals and communities.

ATTC COE-PPW:

How have women's substance use disorder services evolved in terms of gender-specific care for pregnant and postpartum women?

MS. KRAMER:

What I'll say, in general, is that residential programs offered a list of services to the client, whereas now service providers still offer core services and consider the whole woman and identify what meets her and her family's unique needs. Providers are looking at add-on services and support that would be paramount to that woman's success.

Questions to consider might be: Are they parenting? Are there any cultural considerations? What about the inclusion of trauma-informed services? If you're not addressing these issues in ways that are specific to each individual, you're doing a disservice.

ATTC COE-PPW:

How would you respond to those who say including other family members—and in particular, fathers—will water down the concept of gender-specific services?

MS. KRAMER:

I would pose a question: "Because of the new requirements, do you feel that the women's services are going to go away?"

Sometimes, I hear providers concerned that the focus on women-specific services will go away because of a new focus on including fathers in treatment—that's additional work, time, and funding. Although the core services may be similar, you don't provide the same services to fathers and mothers because those are different groups. You do it in tandem, and the mother's services are not going away because you're focusing on the father. It's an addition. More work? I don't think so. You're already doing the work. You're just not writing it down. It's more protocols, more processes. We need things written down to provide evidence and documentation that you're providing those services.

ATTC COE-PPW:

What are some of the other considerations that we need to look at when we're talking about engaging the father in a family-centered approach?

MS. KRAMER:

When there is a pregnant and/or postpartum woman receiving residential services, we can provide services to the father of that child. However, it's not a requirement that the mother and father receive services together.

When someone is identified as the father or co-parent, we provide resources, information and sometimes training and education around issues of intimate partner violence/sexual trauma. Should the father be incarcerated, we still try to connect with their case manager and ask what types of services he may be receiving. Just because fathers may be incarcerated for an extended period of time, they're still a father who, at some point, may want to get back in touch with their child. We can't just leave that person out of consideration.

Another factor to consider is co-parenting. Providers know that both mothers and fathers can be dangerous—they can be abusers, they can be perpetrators, they can be survivors, they can be victims—they're on both sides of the house. We're just doing a disservice to that child if we don't check in with the father, identify trauma and potential resources, regardless if the mother and father have an ongoing relationship. At times, fathers don't know what their rights are for visiting their children. We provide education and information on father/non-custodial parent's rights.

When there's a history of intimate partner violence, safety is paramount. Our philosophy is to do no harm. If the father has been violent in the past, we can say, "There's been some harm. These are the things that have happened. This is not who you are, these are the actions. Because of what has happened, now you're in this situation ... as a father. Do you want to be with your child? Here are some of the things that can be done."

ATTC COE-PPW:

How would you describe a family-centered approach, and—within that—who would you say is defining the family?

MS. KRAMER:

The way the current system is structured, the woman's treatment is funded. The woman identifies what family members or supports she wants included

in her treatment—she may include community members, sponsors, and so on. Family support can change as an individual identifies and defines who and what are healthy relationships.

We've had high levels of success when we started providing resources to some of the people the mother didn't want to include. Because as time goes on, she starts looking through a different lens. She receives education and support around healthy relationships, communication, boundaries, all those things that can start rebuilding those bonds and relationships with the people she thought perhaps she didn't want to have anything to do with. And, of course, those resources also help her identify the people whose negativity would make them inappropriate for her support network.

ATTC COE-PPW:

How would you describe a family-centered approach?

MS. KRAMER:

In my opinion, I can see that the tenets are there for the family-centered approach; however, as a system, we don't necessarily have family-centered care defined. In order to incorporate a family-centered approach into practice, we need protocols and assessment tools. To my knowledge, there's no tool that operationalizes a family-centered care approach.

The family-centered approach looks like this: The pregnant woman is the center, the hub of the wheel. We first assess her needs and provide core services and treatment. In that assessment, we assess and have a conversation about her family. The various components of the program (e.g., partner violence, trauma services) are the spokes. The rim that connects the hub and spokes is our family-centered approach.

ATTC COE-PPW:

How important is the role of culture in the PPW and women's services?

MS. KRAMER:

In our society, there are many powerful ways our cultural connections can impact us. Individuals who experience trauma—that is a cultural group. All of our connections are part of our culture. If someone has experienced intimate partner violence, it becomes part of their culture. If they have

experienced sexual violence, if they have experienced the loss of a child, or if they have experienced having eight children, those are all different cultural environments, groups, and ways of moving through the world.

Let's say there are two women who share the experience of having eight children. There will be some similarities and some possible connections in some areas, but in other areas there will not be connections. Services to meet that individual's unique needs cannot happen if one fails to consider all possible connections.

We need to consider all cultural connections and then add on racial or ethnic factors, traditions, ceremonies, and religious beliefs. If we don't take the time to identify what those unique cultural needs are, we might be missing opportunities for that person to be successful in recovery.

In order for service providers to make effective connections with the woman's culture, they need to understand a little bit of their own culture, their own prejudices. The staff also needs to understand how their own beliefs may impact how they provide services. It's important that they prepare for individuals who may be from a similar culture but may feel different about traditional ceremonies/customs.

The more we learn about the whole individual, the better we understand their different cultural connections. One can begin to understand the historical/ancestral trauma that exists for many populations and how that trauma doesn't go away. Becoming sensitive to generational trauma can truly impact your success with people.

ATTC COE-PPW:

What recommendations around culture would you offer to providers working with pregnant and postpartum women?

MS. KRAMER:

Within your assessment, incorporate cultural questions that spark a conversation. Then I can get to the core of what can really benefit this family culturally. It also helps me know who and what is not important to that individual.

Creating Family-Centered Services for Latinas in Boston

An interview with Iliana Ojeda-Rivera, MA, CADC, LADC I
Conducted by Lonnetta Albright, for the ATTC CoE-PPW

INTRODUCTION

Iliana Ojeda-Rivera has more than 20 years of substance use disorder treatment experience. She is the Director of Residential Treatment Services for the Boston Public Health Commission, directing Entre Familia, a 20-bed facility for Latina pregnant, postpartum, and parenting women and their children; The Transitions Program, a 45-bed, co-ed transitional support services (TSS) facility; and The Wyman Recovery Home for Men. Ms. Ojeda-Rivera participated in the development of the Boston Consortium Model (BCM), a trauma-informed women's treatment model on SAMHSA's National Registry of Evidence-Based Programs and Practices (NREPP), and has had the opportunity to train many organizations on that model. She is also a co-trainer in the Latino Behavioral Health Workforce Training Program, Massachusetts Department of Public Health (MDPH), and a graduate of the Bureau of Substance Abuse Services (BSAS)-funded Substance Use Counselor Certificate Program for Latinos. Ms. Ojeda-Rivera is a 2011 alumnus of SAMHSA's Women's Addiction Services Leadership Institute (WASLI) and served as a WASLI Coach in 2013. As a person in long-term recovery, she finds that her experiences have given her a depth of insight into the needs and challenges of the women she serves.

ATTC COE-PPW:

What drew you into this work?

MS. OJEDA-RIVERA:

I am a woman in recovery. I started my recovery journey in the '90s and came to Boston in 1994, to a family residential program. I have four children, and

I entered the program with two of my children, five-year-old twins. As time went on, I reunified with my other two daughters, who were 15 and 10 years old at the time. By the time I completed a one-year residential program, I had all my children with me.

I started to work in the field about a year into my recovery, as a volunteer at another Latino family residential program. I started going to school and found a passion for doing this work. I have been working in women's treatment ever since.

ATTC COE-PPW:

At what point did you know that women, particularly pregnant and postpartum women in recovery, would be your life's work?

MS. OJEDA-RIVERA:

I went to work as a case manager with the MOM's outpatient program directed by Dr. Hortensia Amaro. It was very early in my career that I realized this was a special population and that I enjoyed doing this work with pregnant and postpartum women.

ATTC COE-PPW:

How did Entre Familia get started? What were some of the barriers you encountered?

MS. OJEDA-RIVERA:

Dr. Hortensia Amaro and Rita Nieves were the founders of the organization. I was working with them already at their outpatient program at the time. There were sister programs, too. So I've seen how Entre Familia has evolved—how it's come together and how it's evolved throughout the years.

Entre Familia was founded in 1996 by Hortensia Amaro and Rita Nieves in response to a need for residential family services. Throughout its 21 years, Entre Familia has changed a lot, grown from nothing. One of the challenges early on was that there were not many other programs to go by. So, many of the things you use to start up your program—like policy, procedures, rules, and phases—were borrowed from other programs.

Dr. Amaro believed in a relational model and gender-specific treatment; she's a pioneer in trauma-informed care. She brought those things to the program,

and the staff was trained by experts in the field to be able to do this work.

Maxine Harris, Justine Miller, and other people who were blazing trails at the same time worked right alongside Dr. Amaro with Francine Feinberg—they were instrumental in pushing women’s issues into our consciousness.

ATTC COE-PPW:

Is there a particular barrier the program encountered that stands out for you?

MS. OJEDA-RIVERA:

Funding for childcare ... I would actually call it “family services” because it’s not just about watching the children when moms are in groups.

It includes providing therapeutic services, like one-on-one family-specific services, especially with children who have experienced trauma, violence in the homes, or those who have lots of behavioral issues. Being able to hire staff who specialize in these areas has been a struggle. It’s hard to get external services, too. There’s always a waiting list for children’s services. And sometimes, we have to wait a while before we get children set up with a proper mentor. That’s one of my wish list items: to have a child therapist on-site who can work with children and moms on bonding and therapeutic relationships among the family members. Not just moms, but external family members, too, coming in and doing family work—grandmothers and grandfathers, too.

ATTC COE-PPW:

When women go into your residential program, can they bring their children with them?

MS. OJEDA-RIVERA:

Yes. They have to have a child with them, and they can have as many as they need—up to five. We’ve had women with four children. It’s up to them.

ATTC COE-PPW:

Is there an age limit on children who can live with moms?

MS. OJEDA-RIVERA:

Children can live here during their 17th year. When they turn 18, they’re no longer considered a child; they are considered adults.

ATTC COE-PPW:

As we broaden the scope of women’s recovery and wellness services to include all family members, some say we’re watering down “gender-specific” care. How would you respond to this concern?

MS. OJEDA-RIVERA:

I actually see addressing the needs of the family and the partner as gender-specific, and actually as advancing gender-specific. I can’t cite specific research now, but I know Dr. Amaro turns the implications of the research around, confirming the family as such a major part of what makes a woman what and who she is—the fact that she so often identifies herself as part of a family. Including the family in the process has been great for our retention and has really helped improve the family relationship, which is an essential piece of their ongoing recovery process.

It’s being able to feel that connection and support from your family members. It’s really difficult for women to be successful when they graduate from the program, and I understand that there are a lot of concerns around introducing the father and that whole dynamic while the women are in treatment. But what other time would be best, when the stress of being in that relationship intensifies their need for other support systems, including the help of therapists? While she’s in treatment, we have the support of all the staff for a woman who may be struggling in her relationship.

We do have family members whom would not be appropriate to involve, due to violence, not being supportive of their children, or who have been absent. We definitely understand those relationships, and we don’t push for those to get better. But in relationships where women are identifying a need to work on those connections, we definitely work with that. It’s not helpful just to ignore the fact they have these relationships ... that they belong to a larger entity. Instead, we want to find out how they can maneuver and work with those relationships, and while they’re in treatment is the ideal time to do that. Where else would they get that opportunity?

ATTC COE-PPW:

It is often said that family is the foundation of Hispanic/Latino culture, familia or family. How true is this statement for the families that come to Entre Familia?

MS. OJEDA-RIVERA:

Our work is specifically focused on Latina women. We've admitted some multiracial women who have identified with their other nationalities. But, for the most part, at least 85% to 90% of the women have been Latina. The family is at the foundation of these women's lives. Her belonging to this family system is what keeps that desire to be a better mom, to be a better daughter, and a better partner alive, and feeds her self-identity.

We've also had women who have female partners. We include whomever she's identifying as part of her family system. If the partner needs addiction treatment, case management, or mental health services, we connect them to outside resources if we don't supply it or offer it within our program.

ATTC COE-PPW:

How would you describe the family-centered approach at Entre Familia?

MS. OJEDA-RIVERA:

From the beginning of a woman's intake process, we ask her about family members who are supportive. Mothers or fathers—whoever is involved with them—we include them in the admission process, if the client wants that. To be in this program, women must be pregnant, postpartum, or parenting. And to remain in the program, they must reunify with their children within a 30-day period—it's part of the family-centered nature of our program. It has to be a family unit.

Men and other family members are an essential part of the women's treatment, although they don't live within the residential program. Our intake process includes a large piece around family involvement, so, right from the beginning, we can include them.

Our guiding principles, our mission, and our philosophy are displayed throughout the residential facility—posters with family images, pictures of dads with children, moms and dads together—we have visuals that reflect our values and principles.

All family members go through family orientation, where they get information about our rules, our expectations, a summary of what our program is about, and what they can expect their family will be experiencing while they're here with us. We include all our contact information on those forms, which they can take back to their homes with them, and refer back to throughout the time they're here with us.

We have a male staff member who comes in on Sundays and meets with male family members and those who are father figures to their children. He provides case management services and SUD counseling, and organizes events that include dads throughout the year. He also provides orientation sessions and helps them settle into the program. We host a lot of family events. We have family service coordinators who work with our families and really look at the whole family unit and how we can best support them. In our weekly clinical team meeting, we include the external family members in our discussion.

ATTC COE PPW:

Were there concerns about involving men who had a history of violence?

MS. OJEDA-RIVERA:

As staff, we look through our fears and our biases that these partners may not be good for the women. We practiced for so long, "Oh, no, you can't be in a relationship with him. You have to earn the right to see him and have communication with your children's father, or to have passes with him and all that." Having the fathers be part of their process from day one has been very different for many of our staff, but I think, at this point, they're used to it. We've worked through many difficulties, and we take it on a case-by-case basis.

During our process, we've learned many lessons. We've also trained staff on what to look for, what are some of the things we need to be aware of, how do we keep ourselves safe, how do we have conversations with dads who are escalated—or concerned, let's just say, or expressing concerns in a really verbal way? When do we go get a male staff member to come in and have a conversation with the partner if he might be more responsive to a man? We have family meetings and try to work through some of these challenges. The staff has really come around, to the point where I'll hear them joking around, like, "He's so great, I wish he was our client instead of her!"

ATTC COE-PPW:

What are some of the challenges in working with your Department of Children and Families (DCF)?

MS. OJEDA-RIVERA:

We're one of the main sources of services to keep the family unit together for women who are struggling with substance use disorders. Our family residential program staff meets monthly with DCF and other times throughout the year. The director of the Department of Children and Families comes in occasionally for updates or trouble-shooting.

DCF has confidence in the work we're doing. We have open communication with them so, they know when they come to us, the women are well supervised 24/7. We help the mom work on having the proper relationship with the DCF workers and help her learn how to maneuver within that system; we're clearly their allies in this process.

ATTC COE-PPW:

Has patient confidentiality been a challenge as your partnership with DCF has evolved?

MS. OJEDA-RIVERA:

We negotiate with DCF about how much information they want us to share. Because it's always been a struggle around how much information they want us to give them about how the woman seems to be doing and what's happening in the program, while we also have a responsibility to protect the woman, her rights, and her confidentiality.

Here's an example: Maybe we'll be struggling with a woman around some of her behaviors, and then with DCF, we may say, "She's doing what she needs to be doing. She is where she needs to be. We're working with her in certain areas," without giving them details. But then, let's say it doesn't work out, and the mom is really deteriorating, and we need to discharge her, do an administrative discharge or transfer her to another program. They'll say, "Well, what happened? You've been saying she's doing well." And we'll say, "Oh, no. We told you we were working with her in certain areas." So, then they feel like we're deceiving them.

But we have to protect the woman in her process, so we have some conflict with DCS around those types of things. We're not hiding things, but there's just so much they need to know—like specific providers and Child Protective providers. So, they need to let us do our work.

At times, they want to dictate to you as to how to run your addiction treatment and behavioral health programs. Our role is to protect the children and the adults, with their best interests in mind, and make sure mom's doing well.

ATTC COE-PPW:

What kinds of partnerships are important to have?

MS. OJEDA-RIVERA:

I believe partnerships with child welfare and other relevant systems and service providers would be major components of their work with family relationships. These external partnerships really support the work you will be doing within residential services. We work with a mental health provider who's external, but has specific clinicians assigned to our program. And they come in and do individual work, family work, and child work. And my wish is to have these services available internally, but that's okay for now. We have external partners, which is great. Having the support of the State is going to be crucial, because, if you can create that collaboration with the State, you know you have an ongoing referral source.

Sober living programs and mental health providers are important external collaborators. Many of our women go to a transitional living program until they get permanent housing, because, as you know, across the country, Boston being one of those very difficult areas—there's not a lot of affordable housing.

Recovery centers in the community are also important external partners. We have collaborative efforts with our recovery community including a recovery center. Before women leave treatment, we connect them to the recovery centers in their community. That way, they have somewhere to go. Some of them are already connected to 12 Steps, which we introduce them to while they're here. Many of them choose not to do 12-Step groups. So, we try to find other pathways for them, and try to connect them in that way.

ATTC COE-PPW:

How important do you think the role of Hispanic/Latina culture is in Entre Familia's family-centered approach?

MS. OJEDA-RIVERA:

I think it's extremely important. I went through a treatment program that was primarily African American and Caucasian. I was the only Latina in the program. I was born in New York and came from a really strong Puerto Rican background. I've always practiced those traditions in my home—our food, our music, our holidays, our traditions, and our rituals were always really strong Latino, Puerto Rican beliefs. I see the same cultural aspects evident in our program.

ATTC COE-PPW:

How would you measure success of your family-centered approach?

MS. OJEDA-RIVERA:

I would say that every case is different. We measure it individually, by family. I say that based on their goals. One of the things we've seen is fathers starting to show up for prenatal appointments, fathers showing up for the visits more consistently, learning how to communicate with staff more effectively. It is women leaving with their children, or fathers wanting to engage in family counseling and work on their relationships—or reaching out and asking for help getting into treatment. Those are some signs of success.

ATTC COE-PPW:

If you had a crystal ball, what would Entre Familia look like in the next 21 years?

MS. OJEDA-RIVERA:

I would make the children and family components much stronger and offer child trauma work. Then, I would have private housing units on our campus. I wish we had half of our campus property used for housing, for women and families to live in, with supportive case management and services in place. That would be my dream.

Meeting the Needs of Pregnant/ Postpartum Women in Cincinnati

An interview with Margo Spence, MS, LSW, LICDC
Conducted by Lonnetta Albright, for the ATTC CoE-PPW

INTRODUCTION

As the President and CEO of First Step Home, Margo Spence provides leadership and guidance to all of First Step Home's programs for the treatment of women with substance use disorders in Cincinnati, OH. She oversees personnel who provide residential, outpatient, and Maternal Addiction Program services; directs the community awareness functions for the agency; oversees the fundraising and budgetary efforts of the agency; provides board leadership and relations; and provides human resource oversight. Spence leads the efforts to provide safe and sober housing for recovering women and their children, up to the age of 12, on the organization's 12-building Cincinnati campus. She has held a variety of positions in local and state organizations, including the Ohio Women's Network of Alcohol, Tobacco and other Drug Programs (OWN), and served as chair of the Council on Alcohol and Drug Addiction Services for the State of Ohio.

ATTC COE-PPW:

How has your background influenced your work at First Step Home?

MS. SPENCE:

I've been working in the field for close to 40 years. I began working in a residential treatment study with girls who were involved in the juvenile court system. From there, I worked in a women's self-sufficiency house, then became a Director of women's halfway houses. I also supervised the women's jail treatment program. For over 16 years now, I've been the President and CEO of First Step Home. We provide addiction treatment for women with children up to the age of 12.

ATTC COE-PPW:

Would you discuss the history of the organization—how it started, and what barriers you've encountered along the way?

MS. SPENCE:

First Step Home started 24 years ago by a group of predominately women who were involved in Alcoholics Anonymous (AA). They became alarmed after receiving numerous calls from women who wanted residential treatment. These women didn't have a safe place to leave their children. This group of women decided to start a 24-hour, seven-days-a-week residential treatment program. We are the only certified drug and alcohol treatment program in Hamilton County that allows children up to the age of 12 to stay with their moms during the recovery process.

ATTC COE-PPW:

At what point did you know that women, particularly pregnant and postpartum women in recovery, would be your life's work?

MS. SPENCE:

Women with opioid use disorders started coming to our doors about five to eight years ago. We weren't prepared to address the needs of these women, so we designed specialized programs for pregnant and postpartum women. In order to be effective with this population, we had to change some of our treatment programming and housing along with a number of other issues. We've expanded our services to include mental health and outpatient services along with expanding our housing units. We have a more campus-like environment now. After clients completed treatment, they had a very difficult time finding affordable, safe housing in the community. So, as houses became available, we purchased those homes, renovated them, and our women can now live within three city blocks of our main treatment facility.

ATTC COE-PPW:

Is First Step Home a SAMHSA PPW program?

MS. SPENCE:

No, we're not. We have women's set-aside funding from the State block grant, Medicaid, and county levy dollars. We have a fundraiser once a year to supplement our program along with other private donations.

ATTC COE-PPW:

What inspired you to start a family-centered program?

MS. SPENCE:

We had a difficult time retaining women because of their pregnancy and other overwhelming experiences in their lives. We wanted them to be successful, and we knew we needed to enhance our services by hiring staff who understood how to engage women and understood trauma.

MS. SPENCE:

In May 2017, we started the Terry Schoenling Home for Mothers and Infants, a 24-hour, seven-days-a-week treatment facility. We're partnering with one of our area hospitals, a nurse's organization, a children's hospital, and Child Protective Services (CPS). Before a pregnant mom delivers, she is admitted and has time to prepare for her baby's birth. After delivery and release from the hospital, she returns to the house and has an opportunity to bond with her baby and receive wrap-around services. Postpartum women can remain in the home for 30 days. After that period, she can return to our regular housing units.

This new program has made it more necessary to collaborate with the medical field, childcare agencies, CPS, and a number of other resources. CPS will be working with the mothers and us on-site. We know CPS is concerned about providing a safe environment for a child. With CPS and our staff working together onsite, we can all get on the same page as to what should happen, what's in the best interests of the mom and child.

ATTC COE-PPW:

From your perspective, how do these programs foster a family-centered approach?

MS. SPENCE:

We're trying to create a nurturing and caring community where women feel supported. We understand the disease of addiction comes along with lapses sometimes. We don't want women to feel ashamed when they relapse. They may need additional support.

ATTC COE-PPW:

Speaking from your 40+ years of experience, what's been the evolution of women's substance use disorder services?

MS. SPENCE:

It's come a long way. Efforts like these are needed and will continue to need a lot of advocacy. I can remember when women were not considered in the criminal justice system agenda or the treatment system. Everything was designed for men's services, and women pretty much received the leftovers. More women are presenting for treatment, but the stigma is still there. However, more folks and service providers are willing to design specialized services for women. There's genuine interest in helping.

I've recently seen so many grant opportunities for pregnant, parenting, or postpartum women, opportunities that you would never have seen before. Treatment providers were once afraid to work with pregnant women because they rarely saw women coming to treatment. Their agencies viewed children as major liabilities. We're moving, certainly, in the right direction.

ATTC COE-PPW:

How would you describe your program design when you think about trauma-informed care?

MS. SPENCE:

Women are very relational; sometimes, just coming into a treatment environment can be traumatizing. Our staff works hard to be respectful, making sure that the client feels safe and protected. I think the field is also recognizing trauma-informed care needs to be part of the equation.

ATTC COE-PPW:

By emphasizing the need for family-centered approaches, do you think we minimize the importance of gender-specific care?

MS. SPENCE:

I understand the concern, but I think of it a little differently. As an agency, I think we need to focus more on family approaches. Our definition of family approach still means the mom/infant dyad. We're considering how to get fathers more involved and providing specialized groups just for the father. The more we're able to involve the significant other in this process, the more we'll be successful.

The women are still involved with their significant other on the outside. The baby's father or significant other may be working in opposition to our goals for mom and baby if we don't involve them in treatment.

ATTC COE-PPW:

Do you see a distinction between treatment and recovery? Are there implications for women's services and recovery?

MS. SPENCE:

Treatment is short term and recovery is long term; recovery might involve maintenance and wrap-around services. Recovery involves the whole spectrum of care, dealing with housing, peer support, and all the other measures that allow a person to go into the community and be successful.

ATTC COE-PPW:

What are some changes you've made in how you provide services?

MS. SPENCE:

Women have always been our identified clients; however, what happens with the child has a major impact on mom's progress. Our focus is really on family. It's sometimes a challenge to get all staff to see that we're really working in a truly collaborative relationship with our partners in the community. Staff are learning to communicate openly with our partners. All in all, that's going to be what's in the best interest of that client and her children.

We were also the first local agency that really dealt with medication for addiction treatment services for pregnant women. Other local treatment providers were accepting the use of methadone to treat pregnant women with opioid use disorders yet were reluctant to prescribe buprenorphine as an alternative medication. We met a lot with organization leaders and staff to talk about the use of buprenorphine. That really took culture change, and it didn't happen overnight.

ATTC COE-PPW:

What other shifts have you seen—in the field or in the community—that have been significant for you and your organization?

MS. SPENCE:

One shift was just moving from a treatment model designed for men to really focusing on what women needed. Another shift we're seeing in our state is a change in attitudes among some recovering persons. Some people think if they recovered a particular way, it's the only way of recovery. That perception needs to change.

We've also had demographic shifts. In the early years, we focused on treatment for alcohol, marijuana, and cocaine. Our population was about 50% African American and 50% Caucasian. In the last two years, we've shifted to probably 95% of our client population being Caucasian with an opioid use disorder. A high percentage of the women say their addiction started when they were prescribed an opioid medication to treat some type of physical ailment. When they couldn't get their physician to prescribe more medication, they began using heroin.

ATTC COE-PPW:

How do you integrate cultural considerations in a family-centered approach?

MS. SPENCE:

We recognize that clients need to see staff who look like them. We're very respectful of the individual and their needs. We make sure women feel respected. We treat everyone with dignity and create a safe place for them to live.

ATTC COE-PPW:

What would be your approach if you were to design or redesign a family-centered program?

MS. SPENCE:

I would like to provide options and offer a safe environment where women can have the option of living with just other women and children, or they can live in more traditional-type family housing. People need to have an opportunity to choose what's best for their own recovery.

Ending the Cycle of Family Addiction through Family-Centered Care

An interview with Kathryn Icenhower, PhD, LCSW
Conducted by Lonnetta Albright, for the ATTC CoE-PPW

INTRODUCTION

Kathryn Icenhower, PhD, LCSW, is the Co-Founder and Chief Executive Officer of SHIELDS for Families, a private non-profit organization with 340 staff, a \$30 million dollar budget and 38 programs that serve over 10,000 families annually in South Los Angeles. She received her BSSW from Ohio State University and her MSW and PhD from the University of Southern California. Dr. Icenhower sits on numerous local, state, and federal coalitions and advisory boards, including the California State Child Welfare Council, SAMSHA'S Advisory Council for Women's Services. She has been recognized by numerous entities for her piloting work in the substance abuse and child welfare fields including an Innovator Award from CSAT for her work in Family Centered Treatment, the James Irvine Foundation Leadership Award, the Visionary Award from the National Association of Minority Contractors, and named as one of the 50 most influential women in Los Angeles by Los Angeles Magazine.

ATTC COE-PPW:

SHIELDS for Families is a leader in the family-centered treatment world. So, Dr. Icenhower, can you tell us what inspired you to start a family-centered program?

DR. ICENHOWER:

Los Angeles was in the middle of the crack epidemic, and there were no services available that would really work for a woman and her children. I was working for the Los Angeles County Drug Abuse Program Office, and I was

overseeing substance use disorder planning. The epidemic had hit hardest in South Central Los Angeles, where there were no services available for substance use disorder treatment for families at all.

The child welfare response to the epidemic was to remove all the children from their mothers, especially at birth. The moment a child was born and was identified as being positive for cocaine, they were being detained. And usually, the child was placed two or three hours away in foster care, not giving that mother any option about how she was going to get her child back. For me, that was just not acceptable, and I needed to do something about it.

So, I worked on a model. It was a day treatment model, where a mother could come to treatment and bring all of her children with her. And, to make a long story short, I decided to leave the County and come out to Martin Luther King Hospital and partner with a very close friend of mine—a pediatrician, Dr. Xylina Bean—in order to start our very first program, Genesis, where a mother could bring all of her children with her to treatment. And we could do something that would help keep the family, as well as this community, together.

ATTC COE-PPW:

The very definition of family-centered care! And speaking of that, how would you define family-centered care?

DR. ICENHOWER:

Oh, defining family-centered care ... I think that's something that folks struggle to define. I try to keep it very simple. It's whoever the family thinks is a part of them. That is whom we target our services for. So, if you're working with a family, whatever issues that family brings to you, then you provide services that will wrap around that family. That doesn't mean you're necessarily the person who provides all the services, but working with a family is kind of a unique thing, because you're dealing with so many different people and so many different issues. Your services have to be just as flexible, and integrated in the community those families come from. So family-centered care is—again, in a nutshell—just providing everything that a family needs.

ATTC COE-PPW:

That must have quite an impact on families' lives. What are some of the outcomes you see when you take this kind of family-centered approach?

DR. ICENHOWER:

The outcomes for family-centered treatment? Let's just say that, ever since we started providing services in a family-centered model, back in 1990 when we first opened our doors, our outcomes have been triple the national average. In terms of successful completion, we have about 75% to 80% of our families who finish the program. And it's not a short program. Our average length of stay is a little over a year. About 13 months is what we average. So, families remain in care for that entire time period.

Our program is also a little unique in that folks have to have their high school diplomas before they can graduate. So, at one point in time at SHIELDS, we had six full-time therapists who were working for us who had gotten their high school diplomas in our Exodus program, gone on to college, earned their master's, and then came back to work as clinicians here at SHIELDS.

ATTC COE-PPW:

You've talked a little bit about some of the successes you've had. What are some success measures you use with this model?

DR. ICENHOWER:

Well, with a family-centered model, there are a variety of different outcomes you can look at. For our children aged 0-5, that includes: Are they developmentally on track? Are they getting all their immunizations? Do they all have a medical home? So, there are many different outcomes that we're looking at with our 0-5 population. With the 5-18 population, we look at: How are they doing in school? What are their feelings about themselves? Are there any mental health issues that we're helping them work through? We use about six different psychological tests with our 5-18 youth, in order to really monitor how it is that they are doing. Do we see any depression there? Do we see anything that we need to address? We know our children are doing well when we see their progress in school, when we see they're moving on to go to college.

ATTC COE-PPW:

And the moms?

DR. ICENHOWER:

With our moms, it's very similar. In terms of successful outcomes: Did they get their high school diploma? Did they enroll in college? Did they complete a vocational training program? Did they get a job? And then we track afterwards, at least up to a year after treatment, to see whether or not they're still abstaining, and whether or not they're still on their path to success as they have defined it.

ATTC COE-PPW:

Most people just do what's guaranteed to be funded. But you—rather than bend yourself into the shape that the funders demanded, you did what you thought was right for the people in your community, and then you found a way to fund it. What was that process like? And what helped you succeed?

DR. ICENHOWER:

One of the things that I think is really critical—and perhaps a mistake that we've made historically in treatment—is that we've set up treatment to be comfortable to the folks who are providing the treatment, instead of developing programs that meet the needs of the folks we're serving. And that goes for whether it's family-centered care or individuals or veterans, or whoever the population is. If we're going to be successful, we need to really start looking at whom it is we're serving.

When we look at the research around women, we know a couple of things. We know that women don't go to treatment because they don't want to leave their children. We know that women leave treatment because they want to be with their children. So, if that's the case, then, in my mind, it made absolute sense to build a program where the children and the mother could be together. And then, it makes sense, I guess, more in a heartfelt way. I'm a mom. I could never imagine being asked to leave my child in order to go do something for myself, because I'm a mother first and foremost. So, my child is always going to be the priority, and the moms we serve are no different.

So, I decided from the get-go to build a program and do whatever was necessary in order to make sure we were providing the services for the entire family unit. Now, that has not been an easy process because—even though this concept is logical in my head—it has not always been logical in the treatment world. So, there are no funds sitting out there that neatly fit this model. You have to do a great deal of work in order to bring that money together.

Now, once you free your mind and look at it in terms of, "This is something

we need to do, so now how do I go out and bring the money in, or bring the services in that are necessary to do it?” instead of trying to take the existing pots of money and make it fit, I think it kind of liberates you. One of the things that—I guess, if I’m being honest here—one of the things that always irritated me is that we only have funding for moms with children 0-5. Okay?

Now, I’m sorry. But our mothers don’t neatly fit their children into that age range. And once you get them, even if they are 0-5, they do grow up. They do get older. So, the funding—you have to figure out now, “How do I pull in the money we’ll need to address those kids as they grow?” So, looking at all of the resources out there and figuring it out—again, starting where your families are—this is the most critical piece you can address.

ATTC COE-PPW:

So, how do you manage to sustain this program?

DR. ICENHOWER:

Sustainability is key to ensuring that you can consistently provide services. So, from day one, I’ve always been on the hunt for money that is sustainable. Part of what has made us sustainable is the federal block grant for our youth and children. I think it’s critical that you look at EPSDT funding (Early and Periodic Screening, Diagnostic, and Treatment, a Medicaid-funded child health program) through whatever mental health system you have available in your community. Then, of course, child welfare dollars that are out there—another piece. So many of your families are usually involved with that system, and that’s another avenue you can use to identify and pull in some resources.

ATTC COE-PPW:

Does sustaining something so comprehensive keep you up at night?

DR. ICENHOWER:

I constantly worry about sustaining this program—or any of our programs—because when I started SHIELDS, one of the commitments I made to the community was that I was never going to start anything I wasn’t able to continue. So, that has been my word to the community for 26 years. And, of course, every time a family goes through this program, I promise them lifetime aftercare—that I will always be here.

So, yes, something I’m always doing is looking for sustainable funding, sources

that we won’t have to keep applying for through a competitive process. How else can we ensure that the money is going to continue to come in?

So, I’m very careful about my selection of resources. In this case, going after one of those grants and implementing a whole system of services—with no guarantee that I’m going to be able to continue them after the three-to-five-year mark when that grant is up—that’s not worth the risk for me. So, again, I go after sources in the Medicaid system, sources in the child welfare and the federal block grant system for substance use disorders, so that I know that money is going to be ongoing. In other words, I don’t build a dream and then hope that somebody’s going to give me the money to sustain my dream. I make sure that my dream is sustained before I implement it, if that makes sense.

ATTC COE-PPW:

It makes a lot of sense, when the well-being of your community depends on having resources that won’t just disappear. I’m so impressed by your dedication, but also by your planning, and your practicality!

DR. ICENHOWER:

Thank you. Now, I will say this: the one thing I did that I had no idea about what I was doing was going out and buying this apartment complex.

So, I would say that, if you’re looking to provide family-centered care, number one, you look outside of the traditional model. But also, I would not recommend to anybody to buy an 86-unit apartment complex straight out of the gate, because I had no idea what I was doing! And I still feel like, 26 years later, I have no idea what I’m doing when it comes to managing this as an apartment complex. But somehow, we’ve made it through.

But again, if you’re looking to implement a program like this, then you really need to know your community, and you need to know what those families look like: what kind of program, what kind of facility, what kind of setting is going to be most effective for them. The average number of children we see in our families is three and a half, which means that—in case somebody wants to copy me and thinks this is a great idea—that I can’t go out and get an apartment complex that has one- or two bedroom units, because it will not meet the needs of the families we serve. I can’t go out and buy a residential facility and think I’m going to somehow stuff these kids into the program.

In other words, if you’re committed to providing services to the entire family, then you have to figure out a way to do it that’s going to ensure that you can actually provide the services to everyone.

ATTC COE-PPW:

Excellent point! So, the next time you go out and buy an 86-unit apartment complex, you'll remember that. But you've done it. And you've made it work! So, this has been an amazing story. What are some of the barriers you've run into along the way? And do you have any specific examples of how you have overcome some of these barriers?

DR. ICENHOWER:

Well, in terms of barriers, we have to go back to funding. Because one of the barriers, obviously, is ensuring that you have funds to sustain the model, funds to build on what you're providing as you learn about new things that are needed. But when you learn that one of the most important things that will be needed is safe housing, you run into one of those areas where the rules of the whole government system pose one of the major barriers. So now, let's go back to this property: I can't take my grant money that I get for treatment and use it for a mortgage because I can't use it to purchase anything. You can't use federal grants to do any capital expenditures.

Instead, I had to get creative about how I approach this. So, I set up another separate nonprofit corporation that actually bought this property and owns it. Now, SHIELDS for Families can lease this property from SHIELDS Housing Corporation, and therefore use the money—the grant money—for leasing. But I can't use it in order to buy. I think that's one of the biggest faults in our system because it means we're having to spend a great deal more money leasing than we would if we were able to utilize the money to purchase.

And it really affects sustainability, if you're in a situation where you're not owning, but you're leasing a facility. Because again, you want to ensure that you have control over whatever facility you're using, and ultimately, the only way to do that is to own it. But we have a system setup—our whole grant system in the federal government—that's based on being temporary. Grants are for three to five years; you're very limited in terms. You can't really build sustainability through grant funds, so you have to figure out an alternative way to do that. I think that's been the biggest barrier in terms of infrastructure.

ATTC COE-PPW:

What about on the programmatic level?

DR. ICENHOWER:

On the programmatic level, I think one of the barriers is staffing. Programmatically, you have to have staff members who truly can work with a family. And while that sounds simple, it's not. One of the things I did when I started the program is that I hired staff, and I intentionally hired staff who had never worked in treatment before because I knew that what I was doing was a different way of approaching substance use disorder treatment. And I didn't want to have to try to change someone's philosophy.

When I talk about traditional treatment, number one, I'm really talking about focusing on an individual: the feeling that the person who has the substance use disorder—in this case, the mother—has to take care of herself first, or she'll never be able to establish her recovery. I personally don't believe that's true. And 26 years have, I believe, demonstrated that people have different roles. They're mothers, they're fathers, they're sisters, they're brothers. You can work on those things concurrently. As a mother, I cannot put my child to the side and not address my child, or my children, when I'm working on myself. To ask someone to compartmentalize ... I don't think that's a realistic thing to do.

So, that means you have to find staff who agree with that particular philosophy, or staff you can train in that particular philosophy. And, I mean, if anybody has worked in treatment before, it's very, very different. You have to roll with the whole-family-whole-community paradigm, and become a part of it. You have to have an organization that supports that particular philosophy—which means you have an organization that treats staff like family in order for staff to be able to understand how to treat the clients we serve like family.

But doing that—and building that—requires continuous training and retraining. And making sure that, when you're interviewing staff for positions that come open, they really, truly have an understanding of that particular way to approach a family. That includes looking at their level of understanding through your assessments, through your interviews—even sometimes taking them to the site in order to see their comfort level there. So, the challenge of finding the right staff is one of the biggest barriers you're going to face.

ATTC COE-PPW:

You've really made good use of some of those learning experiences along the way. What about policy, and what we've learned as a field while this approach has evolved? Those policy missteps can leave us with some valuable lessons. How has the field's evolution process changed the way SHIELDS provides services?

DR. ICENHOWER:

Well, there are always some things that have fascinated me in the treatment world—and I've been in it for 30+ years—concepts like, “You have to be clean for a month before you can come into treatment.” That's always been the one that fascinated me most, because if somebody can stay clean for a month before they come into treatment, they probably don't need you. They probably can do that on their own.

And this whole concept of, “If you use or you relapse, we throw you out.” Again, that's why they're there. They're there because they have a problem with using substances. So, if you throw people out because of the problem that brought them to you, that's totally illogical to me. So, again, I think this goes back to what I was talking about in terms of finding staff who understand that this is a chronic, relapsing disease. If folks are using, there's a reason why they've used, and we look at it in a therapeutic way and address that relapse, as opposed to just throwing people out because of it.

ATTC COE-PPW:

What about policy when it comes to fathers or partners? What have you seen and what does the field seem to be learning?

DR. ICENHOWER:

When we talk about having dads here—I guess, bottom line, ours is just a program without a whole lot of rules. Folks always want to have rules because they want to control people, and the biggest thing about family-centered treatment is that you don't control people. You can't change them; they have to make those decisions themselves. So, the only real rules we have here are that you go to treatment, and you follow curfew, and the curfew is more for safety issues than for anything else.

Back to the partners being involved in treatment: Of course they're going to be involved in treatment because they're a part of the family. Again, I think it's just one of those unrealistic things, having a residential facility that's co-ed

and trying to keep folks from having relationships with each other. Now, see, that's just ridiculous to me: Folks are going to have relationships.

We cannot say to people, “You can't have a relationship for a year,” or “That person is bad for you, so therefore, they can't come.” We need to accept a family where they are, with whoever it is that they bring with them. One of my favorite lines is that, “It's much easier to let people in than to keep people out.” So, if you have a mother who's in a relationship that I may not think is the best relationship for her—but that's the person she wants in her life—then I have to respect that and work with her wherever she is.

Look at our completion rates. If 80% of your families are completing treatment that lasts a year or more, then, in my opinion, we must be doing something right. Those parents are getting back together and trying to work with their children. And if there's an issue—an anger management issue, or even an intimate partner violence issue—instead of trying to keep people separated, why don't you try to work on addressing those issues in order to help them move on together in life?

ATTC COE-PPW:

If you had a magic wand, and you could wave it and make your vision happen, what would it be? What would it look like? In many ways, you've made your vision happen in Compton. So, would your dream be now, to see these family-centered models grow nationwide?

DR. ICENHOWER:

I am really hopeful that family-centered treatment is finally going to have some momentum in this country and move forward. I think that, for years—I'll just be honest—for years people did not believe my outcomes. And then when they finally did believe my outcomes, instead of trying to replicate a model that's shown itself to be very effective, they kind of dismissed it and said, “Well, it's because they have this unique situation there. It couldn't happen anywhere else but there.”

I want to emphasize that, number one, there was nothing here. We started from scratch. There were no resources in this community, and it was because of the determination of the folks I worked with, and the fact that we dug in and did what we knew needed to be done. That could be done anywhere.

I'm excited to see that finally folks are, I guess, kind of taking off the blinders, opening up their eyes and seeing that there are different ways we can approach things. We don't have to put things in boxes because our field has

always done that: “We have a residential program, and we have an outpatient program.” And over the last few years, “Okay, now we have a day treatment program.” Everything has been in boxes.

ATTC COE-PPW:

It can be hard for folks to get out of those boxes, can't it?

DR. ICENHOWER:

But we don't have to do it that way. We can do anything we want. There really is no restriction. We have to move forward. And for families who need services, we need to free ourselves to design models that fit our families and our community. I'm not saying that how I've done it here is how you're going to do it in St. Louis, or in Maine, or in Oregon, or in a group I'm working with in Spokane, or Alaska. I'm not saying it's all going to look alike. Quite the opposite: It needs to match the families in your community.

And you can't be afraid to try. The funding is out there. Sometimes, you have to open up another door and look through it. I mean, when I started, I didn't have any idea I was going to become a child welfare provider, or a mental health provider, but that's what I needed to do in order to make it work for the families. In order to be effective for every mom, every child, every partner ... that's what I needed to do. Again, I'm not saying that you need to go out and become a mental health provider or a child welfare provider. But you need to partner with people who offer those services so you can make sure your families get what they need to succeed.

ATTC COE-PPW:

Start with what people need and keep that in sight.

DR. ICENHOWER:

Yes. And it is doable. There are supports that are out there now, and they can help. There's a growing body of information. There's a growing body of research. I believe that our families deserve this. We talk about it being a family disease. We talk about it being intergenerational. We have to do something to stop it—to keep it from passing on from generation to generation. We've done that here. I have children who came in when they were babies. They're now 25-, 26-year-olds. They have absolutely no idea what it's like to live with someone who has an active substance use disorder—

or what that lifestyle even looks like. None at all. They're in college. They own businesses.

They know what their mothers tell them about what their life was like—living on the streets, living on freeways, not having any food to eat, worrying about where you're going to lay your head the next day. Those are just fairy tales to them, because they've never experienced that in their lifetime. That's what we should be doing. We should be moving forward a generation of children who never, ever have to experience that substance abuse lifestyle.

We can do it. It's a commitment, but it can be done. If we've been able to do it in Compton, then it can be done anywhere. That's how I want to put it forward: It wasn't about us having the resources here. It was because we were determined to do it. That's how it got done.

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