

Women and Children: Therapeutic Community Substance Abuse Treatment

Sally J. Stevens, Naya Arbiter, and Robin McGrath

INTRODUCTION

The need to increase the availability of treatment for pregnant women who use drugs, combined with the difficulty in persuading many such women to enter and remain in drug treatment, is among the most persistent and troublesome problems in the treatment field (Department of Health and Human Services, 1991). Alcohol and other drug (AOD) abuse among women has been on the rise, particularly injection drug use and use of crack cocaine. Of the 9.5 million drug users in the United States, over 5.5 million are women (*New York Times*, 1990).

In Arizona, the problem of AOD abuse among women is overwhelming. In Phoenix, Arizona, 69 percent of all women arrested test positive for drugs (Department of Justice, 1990). Even if substance abuse is identified, there is a considerable dearth of substance abuse treatment programs available (Arizona Association of Alcohol, Drug Abuse and Mental Health Treatment Programs, 1990). Drug use by mothers has increased at an alarming rate. Yet many pregnant women and women with children are unwilling to enter substance abuse treatment. Several reasons have been cited for their unwillingness to enter treatment, including (1) lack of desire, (2) transportation difficulty, (3) type of treatment offered, and (4) lack of support of significant others. However, the "lack of adequate child care" has been cited as the number one barrier to women seeking drug treatment (Stevens and Glider; 1994). Too often pregnant women and mothers are faced with a choice between treatment or caring for their children, and their fears of putting their children in foster care and/or losing custody of them frequently lead to avoidance of treatment (Finkelstein, 1990).

To address the AOD treatment needs of pregnant women and women with children, Amity, a nonprofit therapeutic community (TC) based in Tucson, Arizona, began providing services to this population in 1982 for a select few children whose living situation was simply horrific. Amity had been providing

newly hired female director of programs, Amity's 18-month TC put women's issues and needs at the center of its efforts (Stevens, Arbiter, and Glider, 1989).

Some changes included increasing the ratio of women to men in treatment; increasing the number of female recovering staff demonstrations or role models; adding groups, seminars, retreats, and workshops that focused specifically on women's issues (e.g., emotional safety, building female friendships, molestation, rape, abortion, prostitution, and children). In 1985 it was decided that a small group of children should come to live with their mothers in treatment. This decision was a natural extension of what Amity was already doing and a necessary endeavor. These children were in dire circumstances, some living among drug users and dealers, some living in extreme poverty, and some living in unhealthy and emotionally devastating situations. Although this pilot project was unfunded and small (11 children), the positive impact it had on the mothers and their children, as well as on the overall community, was noteworthy (Stevens and Glider, 1994).

Believing that the TC could be successfully adapted from the traditional model that does not include children, Amity staff used the positive outcome data from the pilot project and applied for federal funds to provide services for addicted women and their children. In 1990 Amity received a grant from the National Institute on Drug Abuse (NIDA) for research and services for 40 mothers, half of whom would be randomly assigned to have their children in treatment with them. In 1992 Amity received a grant from the Center for Substance Abuse Treatment (CSAT) for services for 20 pregnant or newly postpartum women. Located on a 23-acre ranch east of Tucson, Arizona, pregnant women, women with children, and women who are childless live each day in a TC that has been modified to address their special needs.

Therapeutic Community Model and Philosophy

In the early 1960s the TC emerged as a self-help alternative to the existing conventional treatments. The foundations or roots of the TC are based in the tradition of the Alcoholics Anonymous (AA), 12-step self-help model (the 12 Step program). Synanon, the first TC, considered itself not a treatment agency but a learning community deliberately excluding elements of mental health and medical models. This basic philosophical difference in part enabled Synanon leaders to maintain a setting inclusive of children for all of its functioning years. Female addicts who entered Synanon had the option of bringing their children with them into the learning community (Arbiter, 1991). Other TCs for women with children followed, including Odyssey House, Eagleville Hospital's Family

As TCs developed throughout the United States, most did not include children; this was a significant barrier to entering treatment for women. For the most part; pregnant women and women with children were ignored until the late 1980s, when the plight of substance-abusing pregnant women and mothers was heard and federal priorities began to include substance abuse treatment for women with children. Consequently, when looking at the TC from a historical perspective, it becomes evident that the idea of women bringing children into treatment is not necessarily new to the TC, although existing TC models must now be modified somewhat to accommodate this population.

The TC perspective has been described in numerous papers and training

curriculums (Arbiter, 1994; De Leon and Rosenthal, 1989; Mullen 1992). Basic TC philosophical underpinnings are retained at Amity's TC for women and children. Like traditional TCs in which the majority of members are males, Amity's TC for women and children view drug abuse as a disorder of the whole person, affecting some or all areas of functioning. Addiction is a symptom, not the essence of the disorder. A global change in lifestyle, not just a reduction or cessation of drug use, remains the goal. If global change occurs, changes in one's values occur, along with becoming emotionally literate. Consequently, decisions can then be made based on self rather than obedience to some "other" or the law. The model remains that of self-help. Women with children, like their male counterparts in community, are expected to live publicly; self-disclosure and "running one's story" is encouraged and is viewed as essential for one's own recovery process and the recovery process of the other community members. Honest, emotionally challenging self-disclosure about one's life experiences paves the way to emotional health and stable and sound parenting practices. The traditional TC is seen as a microcosm of the wider community and is thus viewed as the primary teacher. So too with Amity's Center for Women and Children. In fact, a TC that includes children may be an even better teacher than one without children because it more accurately portrays the real world. Members may encounter additional learning experiences because as parents and role models in the community, they are more apt to examine their own family dynamics. Ceremonies such as the reading of a bedtime story or the wish for a good day as children go to school have more meaning. Consequently, having children in the TC may result in a more profound TC experience.

The majority of primary treatment staff in traditional TCs are recovering addicts themselves. For the most part this is also true at Amity's TC for women and children. Because of the staffs addiction background and their positive change in values and lifestyle, the staff act as role models for the members. Their authority comes from their personal experiences and recovery process, not from a college degree or a training course. Consequently, not only do the staff have a "job" to do but because of their life experiences, they also play diverse and important roles. For example, a female staffer may have the job of food service manager but her role may be that of an elder in the community or a "women who regained custody of her legally severed children," and so on. A female staffer who experienced rape as her first sexual encounter and shortly thereafter began injecting drugs plays an important role in the recovery process of an 18-year-old pregnant new member with this same experience. Part of being a role model in

groups, work components, educational sessions, and so on, in which members engage). As with members, each staffer is expected to be a participant rather than a spectator. Unlike the medical model, in which professional distance is expected, staff and role models develop personal relationships with members in the community.

In addition to staff members who are recovering addicts, at Amity's TC for women and children there are many academically trained staff who have been hired because of their specific educational training and expertise. Amity has two separate therapeutic daycare centers: the Full Moon for newborns and children up to three years of age and the Power House for children three to 11 years of age.

Each center has academically trained staff whose educational and employment background allow for the delivery of excellent services for the children. Staff include a master's-level social worker, a certified special education teacher, and several child development specialists, as well as daycare assistants, some of whom are in recovery and are not necessarily academically trained. Furthermore, some of the children, particularly the newborns, have special medical needs primarily from having been exposed to alcohol, drugs, and/or nicotine in utero. Consequently, the medical staff needed to be expanded to include a registered nurse and a physician's assistant who work with the children and their specific medical conditions. Additionally, these medical staff arrange for the necessary outside medical appointments for the children as well as arrange for needed medical appointments for the mothers. These are often numerous, given that at any one time at least ten of the women are pregnant.

There are many elements in the Amity TC that contribute to its distinctive character. Traditional TCs are residential, with the proposed length of stay between 15 and 18 months. Historically, the traditional TC viewed the community as "family," with the biological family that may have been a part of the individual's drug-using network required to take a limited role, if none at all. In contrast, all Amity TC members are encouraged to examine their family dynamics and rearrange or rebuild family relationships so they are functional. Family members are invited to attend family groups, and the member is encouraged to join them. The planned duration of stay at Amity, like that of the traditional TC, is 15 to 18 months. Family dynamics issues and patterns of behaviors in child raising take an even more important position in the mothers--

healthy parenting skills and practices. Furthermore, children who come into the community have often lived with relatives—a grandmother, father, aunt, and so on—before the mother enters Amity. To ensure that the children's transition to Amity is smooth, contact with family members, family visits, and family counseling also take on a more visible and important position.

According to De Leon (1989a), treatment in traditional TCs is broken up into three phases, with the initial phase (0 to 100 days) focusing on assessment of individual needs and orientation and assimilation into the TC. In the second phase (2-12 months) the individual is challenged to do more personal work; to become more psychologically aware and socialized. During the third phase (13-24 months) the individual strengthens his or her skills for autonomous decision making and prepares for reentry into the wider community. Phases of treatment exist at Amity's center for pregnant women and mothers; however, no matter where members are in their treatment duration, they can participate in a variety of classes and workshops. At Amity's traditional TC for men, new members enter the community, live with each other (their peer group), and participate together in curriculum and groups. At Amity's TC for women and children, staff must consider the women's individual situations when assigning a woman to a peer group or arranging living quarters. If a woman is pregnant and close to delivery, she needs to live in one of the houses equipped for newborns. If a woman enters the community with two male children over the age of three, she must share a two-room suite with either a woman who does not have children or a woman who also has male children. Furthermore, whether the pregnancy is normal or has medical complications and whether a pregnant woman delivers vaginally or by C-section affects her level of participation in the community. Additionally, the emotional, social, developmental, and medical status of each child may also affect the mother's level of engagement within the community. Consequently, while phases and curriculum within the phases are outlined, maximum recognition for individual needs along with flexibility must be present in any TC inclusive of women and children.

Services delivered in traditional TCs are comprehensive, with little need for collaboration with outside agencies. The traditional TC has an organizational structure to each day, with morning and evening meetings basically anchoring the day's activities. Mimicking what one is expected to do in the wider community, members engage in education, work on the property, exercise, and various kinds of therapeutic groups. At Amity's TC for women and children

outside agencies. As discussed above, the medical needs of the mothers and children require the TC staff to work closely with medical centers, hospitals, and special rehabilitative services for children with exceptional needs. With the addition of a children's component, staff must also work with the public school system, foster care review boards, deal with juvenile court, and so on. Women members are engaged in an organizational structure similar to that in traditional TCs but one that works around the schedule of the children. Morning meeting occurs later in the morning, at 9:00 am., so the mothers are able to feed and dress their children and get them to the public school or the appropriate daycare center. Once the children are settled for the day, the women redirect their attention to the scheduled activities for the day. Like their male counterparts in the traditional TC, the women engage in various educational, vocational, physical health, and therapeutic group activities. Although the curriculum at Amity's traditional TC includes the teaching of parenting skills and family dynamics, the curriculum at Amity's TC for women and children has more emphasis on the teaching of parenting skills and family dynamics that includes instruction on mother-and-child bonding, meeting the needs of children, and child development. At 4:00p.m. mothers pick up their children and again attend to their needs. Dinner is enjoyed by everyone together, building extended family and community. For evening activities a co-mothering system in which the women partner up to baby-sit one another's children was established. This allows each woman to attend at least two evening groups or curriculum sessions per week. As compared to their male counterparts, women can spend less time in these activities because of their added child-raising responsibilities.

Some TCs include workshops or retreats that focus on a particular topic or that include a particular subgroup of the community. For example a workshop or retreat might focus on (1) violence in society and one's personal experience with violence, (2) sexuality: societal values and personal beliefs, (3) historical prejudice and one's own prejudicial beliefs and so on. Workshops and retreats may include only members who specifically request in writing to attend, only Hispanic members, only members who have experienced multiple relapses, and so on. These workshops and retreats usually last several days. They are emotionally challenging and often provide an experience that is pivotal in the process of positive global change. Amity's TC for women and children sponsors such workshops and retreats several times per year. Instead of having the opportunity to attend a retreat or workshop without interruption, the women must break to take care of the needs of their children and to be emotionally available for them.

individual child. Some factors include how long the child has been at Amity, the age of the child, and the emotional stability of the child. Thus, the workshop or retreat experience that for many traditional members is pivotal in their process of change is different for pregnant women and mothers. Perhaps the experience is less intense because of the necessary child care interruptions. Then again, the experience may be more intense because of the increased stress that the caretaking of children adds and the need to adjust, back and forth, emotionally between the two very different milieus.

Participant Profile

Currently, Amity's TC for women and children has 75 women: 20 women are either pregnant or have infants under six months of age with them in treatment (CSAT women), 20 women have children between the ages of six months and eleven years who are with them in treatment (addicted mothers and offspring in recovery (AMOR) Experimental), 20 women who have children between the ages of six months and 11 years who are not in treatment with their mothers (AMOR Control), and 15 women are either childless or have children not in their custody because the children are too old, adopted, or legally, severed-in care of the Arizona Center for Clinical Management (ACCM). There are 47 children at Amity's Center for Women and Children, newborn to 11 years of age.

Many of the women at Amity grew up socially disadvantaged, from lower - income neighborhoods and from broken homes. The mean age of the women at Amity is higher than the mean age of 25 that has been reported for traditional TCs (De Leon, 1988a). For the women, the mean age differs slightly for each group: For mothers with children it is 29.45 years; for pregnant and newly postpartum women, 27.2 years; and for women without children, 30.7 years. As in traditional TCs, the women at Amity come from various ethnic and racial backgrounds. Interestingly, women who are mothers or who are pregnant or newly postpartum are primarily of minority backgrounds (62.5% and 56.0%), whereas of women without children, only 30.4 percent are from a minority background.

Concerning marital status, it is noteworthy that only 17.8 percent of the mothers with children and 18.0 percent of the pregnant and newly postpartum women were married at the time of treatment entry. Women who are not mothers but are married comprise 26.1 percent, which is much higher than the percentages

three groups is eleventh grade, but the standard deviation of the educational level is much larger for the women without children. In other words, most of the women with children or the pregnant and newly postpartum women had 11 years of education, whereas women without children were more equally distributed between "no formal education" and "college graduate."

Understandably, when asked about their work pattern the year prior to entering three groups of women approximately 42 percent reported having attempted suicide (see Table 9.1).

Table 9.1
Demographic Variables

with	NIDA	CSAT	ACCM
	Pregnant and		
	Mothers with Newly Post-		
Children	Children	Partum	out
	Women		
	N= 96	N=50	N=23
X Age (%)	29.45	27.2	30.7
Ethnic/ Race	(%)		
White	37.5	44.0	69.6
Black	25.0	26.0	26.1
Hispanic	28.1	20.0	0.00
Native Amer.	9.4	10.0	4.3
Marital Status	(%)		
Married	17.8	18.0	26.1
Widowed	1.0	4.0	00.0
Separated	9.4	6.0	8.7
Divorced	25.0	12.0	21.7
Never married	47.9	60.0	43.5
X Ed. (Years)	11.17	11.86	11.96
Past Year Work	(%)		
Full time	22.9	10.0	47.8
Part time	15.6	20.0	17.3
Unemployed	50.0	58.0	13.0
Cont. Env.	11.5	4.0	17.4
Other (st,rt,hm)	00.0	8.0	4.3
Primary Drug			
Alcohol	27.0	12.0	17.4
Heroin	14.6	4.0	21.7
Opiates	4.2	00.0	8.7
Cocaine	44.8	54.0	34.8
Amphet.	5.2	18.0	8.7
Marijuana	3.1	8.0	8.7
Other	1.0	2.0	0.0
Yrs. of Drug Use (n = 84)		(%)	
0<1 yr.	00.0	01.0	4.3
1-10 yrs.	45.2	44.0	30.4

Table 9.1
(cont'd)

11-20 yrs.	42.9	40.0	47.8
>20 yrs.	11.9	6.0	17.4
Court Refrd (%)	58.3	48.0	26.1
X Total Mos. Incarcerated			
	8.3	8.8	14.6
Assault	(%) (n = 84)		
0 times	19.8	32.0	26.1
1-10 times	18.8	40.0	47.7
> 11	49.0	28.0	26.1
Times Raped*	(%) (n = 84)		
0 times	36.9	42.0	26.1
1 time	15.5	14.0	30.4
2-5 times	19.0	28.0	39.1
>6 times	28.6	16.0	4.3
Ever Attempted Suicide?	(%) (n = 84)		
Yes	41.7	42.0	43.5
No	58.3	58.0	56.5

*Old version of the ASI did not include this question; consequently, then size is reduced by 12.

OUTCOME FINDINGS

All the women who enroll in Amity's Center for Women and Children are requested to participate in a follow-up interview at six, 12, and 24 months post-exit. This includes women who have dropped out of treatment and women who have completed treatment in the three groups, namely, women with children, pregnant and newly postpartum women, and women without children.

Follow-up data for the pregnant and newly postpartum women and the comparison women do not yet include anyone who has completed treatment. Funding for those two groups began in September 1992. With 18 months of treatment, those who have completed the project are now just becoming due for their six-month follow-up: Consequently, the follow-up data reported here include only data from women involved in the NIDA component: mothers with children 6 months to 11 years of age. As of September 1, 1994, the mothers-with-children component had enrolled 94 women. Sixty of these women are currently eligible for follow-up. Of these 60 women, 35 have completed at least the six-month follow-up interview for a 58 percent follow-up completion rate.

Twenty-three mothers who had their children in, treatment with them participated in a follow-up interview. Of these, 12 women were "seed women," that is, women who brought their children into treatment with them to start the community; eight women were "experimental women," or women who were randomly assigned to have their children in treatment with them; and three women were "compassionate women," those who were originally assigned to the control group but because of the dire circumstance of the child(ren) were allowed to bring their child(ren) to Amity. Additionally, 14 follow-up interviews were facilitated with "control women," that is, women who were randomly assigned not to bring their children into treatment with them. Total follow-up interviews included 35 six-month follow-ups, 20 twelve-month follow-ups, and eleven 24-month follow-ups.

The experimental design of this piece of the project was implemented so that a clear picture of how having children with mothers in treatment affects outcomes such as future alcohol and/or drug use, employment, custody of children, and rearrest rates. It should be noted, however, that one must be careful when generalizing these data. Not all mothers who need substance abuse treatment will enter a program that has a random assignment either to have or not to have

choices, such as entering other treatment programs or not entering treatment, may not enroll in a project with this random design. For women who are looking at long prison sentences or who are on the verge of losing custody of the children, the 50 percent chance of having their children in treatment with them is very appealing. Therefore, the women who make up this sample are indeed a subpopulation of substance-abusing mothers.

Although the outcome data are preliminary, data gathered at the follow-up interview show that on average, women who brought their children into treatment with them have had better outcomes than the women who were randomly assigned not to have their children living with them in treatment. Combined data from dropouts and those who completed treatment show that of the women who did not bring their children with them into treatment, 71 percent experienced relapse, 43 percent were employed, 43 percent received some type of government assistance, 36 percent had custody of all children, 50 percent relinquished custody of all children, 64 percent were rearrested, and 71 percent were involved in some form of continuance. Combined dropout and "treatment completee" follow-up data for the mothers who did bring their children into treatment show that 56 percent experienced relapse, 74 percent were employed, 52 percent were on some type of government assistance, 52 percent had custody of all children, 26 percent had relinquished custody of all children, 39 percent had been rearrested, and 83 percent were involved in some form of continuance (see Table 9.2) .

DISCUSSION

From the description of the population served at Amity's Center for Women and Children and from examination of the outcome findings, several issues emerge. These issues include (1) the profiles of the women, (2) the reporting of outcome data, (3) the issue of violence, (4) sensitive issues and self-disclosure, (5) the calculation of "success," (6) the length of stay, and (7) the impact of having one child in treatment. The women who have entered Amity's TC for women and children have very different profiles depending on whether at time of entry they are (1) not pregnant but have children between the age of six months and eleven years, (2) pregnant or newly postpartum, or (3) childless. Therefore, when describing substance-abusing women and discussing their needs, no one single

children, have experienced violence, and are not married, there is wide variability in age, ethnicity, education, work history, drug history, court involvement, and attempted suicide.

Table 9.2
AMOR Follow Up: Early Results

Women	Women without Children <i>n</i> = 14	with Children <i>n</i> = 22
Outcome (%)		
· Relapse	71	56
· Employed	43	74
· Govt. Assistance	43	52
· Custody of All Children	36	52
· Relinquished Custody of all Children	50	26
· Arrested after Treatment	64	39
· Involved in Continuance (Aftercare)	71	83

Notes: Results combine treatment completees and dropouts. For 6-month post treatment interview *n* = 35; for 12-month post-treatment interview *n* = 20; for 24-month post-treatment interview *n* = 11.

Past research has shown that the length of stay in treatment affects treatment outcomes (De Leon, 1988b; Simpson and Sells, 1982; Wexler, Falkin, and Lipton, 1990). This pattern was also found in the data presented in this chapter. When we compare only with those who completed treatment, improved outcomes for the treatment completees are most evident. The relapse rate for women without children drops from 71 percent for the combined data to 25 percent for treatment completees. For women with children the relapse rate drops from 56 percent for the combined data to 18.8 percent for treatment completees. When we examine rearrest data, we see that rearrests for women without children drop from 64 percent for the combined data to 25 percent for treatment completees. For women with children the rearrest rate drops from 39 percent for the combined data to 12.5 percent for treatment completees. Therefore, when the dropout data

and treatment completee data are combined, the positive effect of the treatment becomes less visible. However, as the database on those involved in Amity's women and children's center increases, examination of how length of stay affects outcome can be further illuminated.

With violence so much a part of the lives of the women, more refined measures on violence should be obtained. Anecdotal reports from the women in treatment suggest that the drug-using scene in southern Arizona has increasingly become more violent. Not only are the women the victims of assault but it appears that they are also the aggressor in various assaults. Questions on child abuse, sibling abuse, and domestic violence with significant others should be asked of the women. Furthermore, researchers should specify the level of violence (e.g., "swore at someone" versus "used a knife on someone") and document whether the women were the victim of the assault or the aggressor. Additionally, many of the women have witnessed gang-related violence or have had family members die in various incidents of violence. These "witnessing" experiences should be documented as well, as they may not only affect treatment outcomes but require a revision of the curriculum within the treatment program itself.

Sensitive issues such as the frequency of being raped as well as by whom and at what age have been underreported at intake (Stevens and Glider, 1994). Thus the number of times that "being raped" was reported earlier in this chapter may very well be an underestimation, as these data were obtained at intake (baseline). Researchers should consider asking sensitive questions not only at treatment entry but again after the woman has been in treatment for at least three months. A short questionnaire can be administered individually or in a small-group setting. If the questionnaire is administered in a small-group setting, treatment staff may want to work with the research staff. The questionnaire could then be used. as a "kick-off or "starting point" for a curriculum session or a therapeutic group on the same topic.

In the field of drug treatment, relapse is often viewed as a negative event or even as "failure." Outcome data that simply report relapse versus no relapse add to the notion that all relapses are bad. Previous data (Cameron et al., in review) show that not all relapse experiences are negative. Rather, for some, the experience of relapse may be the key experience that promotes further recovery. If at a follow-up interview a person reports having relapsed, the extent of the relapse

negatively (loss of job) or positively (prompted insight into behavior and use of support group).

In modifying a TC to include women and children one must consider that the amount of time a mother can devote to her own recovery issues is lessened by her added responsibilities to her child(ren). Women with children in treatment must spend time with their children and be emotionally available for them. This limits the mother's involvement in her own therapeutic process; thus she should be given the idea of increasing the expected length of stay to two years.

In summary, modification of the traditional therapeutic community can successfully be made for the inclusion, of mothers and children. In fact, the preliminary data presented here suggest that allowing mothers to bring their children into the TC may promote positive change above and beyond the positive changes observed for women who enter treatment and must leave their children behind

ACKNOWLEDGMENTS

Funding for this project was provided by the National Institute on Drug Abuse (Grant no. 1 R18 DA 06918), the Center for Substance Abuse Treatment (Grant no. 1 H86 SFO 5696), and by the Arizona Center for Clinical Management.

