Enhancing Family Protective Factors in Residential Treatment for Substance Use Disorders

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Substance abuse treatment programs typically focus on reducing attitudes and actions that lead to continued substance dependence and do not always maximize opportunities to strengthen the protective factors that can promote sustained recovery. This article describes a co-occurring disorders residential treatment program for women and their children that enhanced its trauma-informed treatment model by adding supportive treatment components that emphasized protective knowledge and skills and helped build support systems. These protective factors included: (1) concrete support in time of need; (2) knowledge of parenting and child development; (3) social and emotional competence of children; (4) parental resilience; and, (5) social connections. The enhancement included implementing Celebrating Families! (CF!) and an improved integrated case management system that were well received by staff and clients. Evaluation data confirmed that those who took part in these interventions showed significant improvements in recovery, including reduced mental health symptoms, reduction in risk behaviors, and longer program retention.
Substance abuse has long been recognized to play a major role in the lives of families in the child welfare system (Azzi-Lessing & Olsen, 1996). This involvement has led to a strong focus on integrated, evidence-based practices and coordination between the substance abuse treatment and child welfare systems (Marsh & Smith, 2011). The number and severity of problems of mothers in the child welfare system often qualifies them for participation in highly structured residential care in the substance abuse treatment system. A comparison of mothers involved in the child welfare system with those who are not indicated greater treatment needs related to exposure to physical abuse, economic instability, and criminal justice involvement (Grella, Hser, & Huang, 2006). Substance abuse treatment programs offering comprehensive care often have multiple resources to meet these and other needs, combined with extensive experience in the relevant areas. The substance abuse treatment system also offers a modality that is difficult to find elsewhere: highly structured, intensive, long-term residential treatment where a woman can be admitted with her children. This model offers many opportunities to enhance protective factors, which may not receive enough emphasis in residential settings because of the clinical challenge of addressing the complex needs of these families. This paper describes how activities to enhance protective factors can be integrated into residential treatment as part of the therapeutic process.

The advent of the stimulant epidemic in the 1980s brought many women into the child welfare system and was associated with the placement of large numbers of their children into foster care. Much research on substance abuse treatment has been done to demonstrate the importance of participation in enhanced programs to promote positive outcomes for women with substance use disorders and their children (Zweben, 2014). As studies documented the effectiveness of gender-responsive programming, specific services were developed in both women-only and mixed-gender programs. These included a strong emphasis on working with families and significant others, and providing

1Treatment Locator: https://findtreatment.samhsa.gov.
services related to pregnancy, parenting, and domestic violence (Grella, 2008; Grella & Greenwell, 2004). Such services were much more likely to be found in women-only programs, and were related to greater client satisfaction. These programs improved outcomes for women with substance use disorders and their children.

These enhanced programs also met child welfare goals, especially reunification. Grella, Needell, Shi, and Hser (2009) reported that reunification was more likely if psychiatric and family problems were addressed, and if the mothers completed more than 90 days in treatment. This is consistent with earlier findings that when women entered treatment quickly and spent more time in treatment, their children spent fewer days in foster care and were more likely to be reunified with their parents (Green, Rockhill, & Furrer, 2007).

**Protective Factors**

The child welfare system and the substance abuse treatment system both emphasize the importance of protective factors in prevention and treatment. Though they have very different histories and distinct cultures, both systems are focused on lowering risk and enhancing protective factors. Risk factors include stressful conditions, events, or circumstances that increase a family’s chances for poor outcomes. Examples include maternal psychiatric disorders, family violence, persistent poverty, and substance use. Protective factors are those that mitigate risk and promote healthy development, such as strengths that help buffer and support families at risk. These factors can be enhanced in individuals, families, and the larger community. Increasing the strength of protective factors is an effective prevention and intervention strategy to offset risk exposure and promote enduring gains.

Strengthening Families™, developed by the Center for the Study of Social Policy (CSSP), identifies five protective factors: (1) Concrete Support in Time of Need; (2) Knowledge of Parenting and Child Development; (3) Social and Emotional Competence of Children; (4) Parental Resilience; and (5) Social Connections. Many state child welfare systems have used the CSSP framework to develop major initiatives.
focused on building protective factors for the families who come to the attention of or are involved with child welfare. These five protective factors are widely used in child abuse and neglect prevention programming (Browne, 2014; Child Welfare Information Gateway, 2014).

Parenting programs are a major vehicle for strengthening protective factors. Barth and Liggett-Kreel (2014) examined the common components in parenting programs, noting variability in the effectiveness of interventions for various age groups. They reviewed the existing research and its limitations, noting methodological difficulties and many gaps in the research. They stressed the importance of utilizing strategies that include multiple program components that are consistently associated with larger effects, rather than focusing on specific manualized interventions. This more generic approach facilitates wider adoption, allowing for “evidence-informed” parent training programs to become more widely available.

The substance abuse prevention field has also focused on risk and protective factors and has identified the following components: (1) strong and positive family bonds; (2) parental monitoring of children’s activities and peers; (3) clear rules, consistently enforced; (4) involvement of parents in the lives of their children; (5) adoption of conventional norms about drug use; and (6) bonds with community institutions and organizations (National Institute on Drug Abuse, 2002). Similar to child welfare approaches, there is a broad focus on individuals, families, and the micro and macro community. The substance abuse treatment field, focused on severe psychiatric, social, and health problems, has gradually increased emphasis on building resilience by strength-based programming that enhances protective factors.

Long-term residential treatment offers unparalleled opportunities to strengthen protective factors. While many prevention efforts rely heavily on educational efforts, residential treatment offers the opportunity for skill building in an environment that allows for continuous monitoring, coaching, and support. This results in a level of mastery that is less likely to be achieved in outpatient treatment or educational settings. The premise is that these achievements will have a multiplier effect, that
children and other family members will benefit, and that the addiction cycle is more likely to be disrupted. Policy leaders have noted that it is important to move beyond teaching to practice-based skills, but effectiveness trials are lacking (Barth, 2009). Long-term residential treatment offers a promising arena to conduct such studies.

**Development of Strength-Based Residential Treatment for Mothers and Their Children**

A major barrier to women’s participation in substance abuse treatment was identified early in the development of gender-specific programming by recognizing the need to provide child care or a safe setting for her children if residential treatment was appropriate. Beginning in the 1970s, attention to women’s issues by the National Institute on Drug Abuse led to increased research on biomedical and psychosocial issues, which in turn led to efforts to identify effective elements of treatment (Moses & Zweben, 2013; Rahdert & National Institute on Drug Abuse, Division of Clinical and Services Research, 1996; Werner, Young, Dennis, & Amatetti, 2007; Zweben, 2014). By the 1990s, the Center for Substance Abuse Treatment (CSAT) at the Substance Abuse and Mental Health Services Administration (SAMHSA) funded a federal demonstration grant program for pregnant and parenting women that funded comprehensive culturally and gender-specific residential treatment. These programs made it possible for women to enter treatment with one or more children, and remain in treatment for extended periods of time, often a year or more. Such programs appear to be unique to substance abuse treatment.

Evaluation data indicated reductions in infant mortality and morbidity, and improvement in retention and completion rates (Clark, 2001). Other benefits of treatment included behavioral changes in impulse control, judgment, and the acquisition of parenting skills. Recognition that co-occurring disorders among women was the norm facilitated the integration of treatment for psychiatric disorders, as well. Mood disorders and anxiety disorders, particularly PTSD, were recognized as fairly common among women entering treatment (Kessler et al., 1994; Regier et
al., 1990). Trauma-informed models became more common as research-based treatments emerged (Najavits & Hien, 2013).

All these improvements still operated within a context that emphasized treating what was “broken,” but did not include adding positive or strengthening treatments that might help to prevent relapse once a woman was discharged from treatment. More recently, many areas of health promotion have helped to build positive and protective strengths in co-occurring disorder treatment programs. Clinicians recognized the value of strengthening resiliency factors and many adopted these strategies as well, but there were very few evidence-based interventions to help. One program, Celebrating Families! (CF!), emerged as a useful tool for accomplishing some of these tasks (Tisch & Sibley, 2007).

This article describes a residential treatment program, Project Pride, that had already developed culturally sensitive and trauma-informed care, but wanted to provide a broader emphasis on building protective factors for the young families in the program.

In 2010, Project Pride introduced two major changes into the ongoing treatment program for substance abuse, mental health, and parenting. One was the evidence-based program, CF!. This intervention was selected in response to focus groups held with the mothers (with no staff present), where they were asked to identify changes that they would like to see in Project Pride. A common theme was that it would be easier to stay in the program if family drama on the outside did not pull them away. They also wanted help in dealing with conflicting demands made by various agencies that controlled their futures—e.g., child protective services, parole, probation, and so on. Finally, they were eager to have resources available to them that would help them to do well on the outside when they left Project Pride. Inviting extended family members into the program to participate in CF! provided all family members the opportunity to understand addiction and recovery and improve supportive family communication and actions.

The second program enhancement was building an integrated case management model that included all the agencies and programs involved in each woman’s treatment plan as early as possible after admission. The
goals were twofold: to provide each woman with transparent and coordinated management of her recovery, and to build a community support network while in treatment that increased the chances that after a woman left the program, she would have knowledge and experience in becoming an active participant in her continuing recovery. The intent was to ensure that each woman and her family were no longer subjected to scattered and potentially inconsistent recovery requirements. This model also addressed the needs of the woman's children, who were not in residence in Project Pride to the extent possible.

Description of Project Pride

Project Pride is a residential treatment program for women who are pregnant or have young children within East Bay Community Recovery Project (EBCRP) located in Oakland, California. Most residents are at risk of losing, or have lost custody of, their children following investigation by Child Protective Services. Program participation is their best chance of retaining custody or being reunited with their children. All residents have problems with alcohol, and the majority are also methamphetamine users. Research on the effects of methamphetamine use has shown that women users have very high rates of psychological problems and extensive histories of psychological and physical abuse (Cohen et al., 2003; Zweben et al., 2004). Thus, they require a high level of attention to coexisting psychiatric disorders (Zweben et al., 2004).

Project Pride was launched in Oakland in 1994 as part of the CSAT Demonstration grant program for Pregnant and Parenting Women. Research findings had indicated that children were a major consideration in women's decision-making about whether to enter and remain in treatment. Using evaluation data, the federal demonstration program sought to show that women who could enter residential treatment with their children would remain engaged and have positive outcomes. Indeed, during the CSAT grant period, six California demonstration programs were designed, evaluated, and were found to produce dramatic positive outcomes. In 2009, program completion rates averaged between 60% and 70%. An average of 70% of the women remained drug-free at six
months post-treatment. Criminal justice involvement was reduced by 90%. The majority (65%) of women were employed or in job training at the time of discharge, and 75% were reunified with other children who had been placed in foster or kinship care. All programs reported positive outcomes for the children, as indicated by improved physical, mental, and social functioning. Despite the mothers’ high-risk pregnancies, 90% of the children were born full term, free from substances, and without any known medical problems (California Perinatal Treatment Network, 2010).

**Strengthening Protective Factors**

Project Pride uses the Strengthening Families™ approach developed by CSSP (Child Welfare Information Gateway, 2014). Although not developed for mothers with substance abuse issues, the approach is consistent with those identified in the substance abuse prevention literature and reflected in the CF! intervention. Staff prioritized the five protective factors and activities that they viewed as the most important in strengthening resiliency and identified strategies to implement those strategies in Project Pride (Browne, 2014). Some of the concept labels were adapted so that specific activities could be documented in the treatment program.

Given the primacy of parental influence in children’s lives, it is important to support parents in understanding and meeting the child’s developmental and emotional needs. Staff members work to help the parents increase their understanding of the child’s needs, worries, and coping style. The intent is to promote the child’s well-being by strengthening both the parent’s understanding of the child and their mutual relationship. Working closely with the parents to help them become the “experts” in their children’s lives is the first step. This is done through the following:

**Concrete Support in Time of Need:** Most mothers enter Project Pride in crisis caused by loss of custody of their children, incarceration or other legal involvement, current or impending homelessness, and other challenges. By providing treatment, safe housing, access to healthcare and public benefits, employment assistance, child care, and other
immediate supports, Project Pride helps address their immediate needs, setting the stage for in-depth services. Since virtually all of the mothers who enter the program arrive with court supervision and other legal involvement, the integrated case-planning and management services are of ongoing help to residents in their recovery.

**Knowledge of Parenting and Child Development:** Daily parenting education classes are provided by mental health staff at Project Pride. The classes help mothers understand the developmental needs and abilities of their children, how to intervene and set limits to create safety for them, and how to create rituals and structure to more easily manage their children’s lives. One weekly class serves as a group problem-solving forum for parenting issues that may arise. In addition, staff monitor parent/child interactions and intervene immediately to provide assistance and identify alternative strategies to help parents cope with frustrations. The CF! program, described in more detail below, involves the extended family to help ensure the continuation of the progress after discharge.

**Social and Emotional Competence of Children:** All children are screened for developmental and mental health needs, including their social and emotional development. An individualized treatment plan is formulated for each child and for each family. This includes parent/child therapy and referrals to individualized programming in response to identified treatment needs. Since mothers live at Project Pride for an extended period of time, Early Head Start considers it a home and provides home-based services. All children are provided with onsite child care that enables ongoing assessment in a child-friendly environment. Older children can participate in CF! starting at age 8, and are divided into two age groups: 8–11 years old and adolescents. Those who participate can be provided with referrals for assessment and services through local Family Service programs.

**Parental Resilience:** Project Pride provides individual and group counseling for mothers to help them maintain sobriety and understand the effects of their own attachment issues, trauma, and violent experiences on their relationships with their children. They are helped to recognize that their children have needs that differ from, and may compete
with, their own needs, with the ultimate goal of supporting the mothers to develop healthy strategies to cope with the pressures of parenthood.

**Social Connections:** Since women do not recover in isolation, but in community, mothers become part of a positive peer group of similarly situated women who can understand their struggles and provide concrete support. Mothers are encouraged to participate in 12-step programs to enhance their community-based supports for recovery. In addition, by engaging their extended families and friends through the CF! program, Project Pride aims to help reduce the familial isolation so many women experience when others in their family and social circle may not understand or be committed to recovery.

Among these protective factors, staff identified improving parental resilience and social connections as the two most critical areas of recovery. This led to the program enhancements described below.

**Strengthening the Extended Family**

Project Pride implemented Celebrating Families! (CF!), a program designed specifically for families in which one or both parents have a serious problem with alcohol and other drugs and are at high risk for domestic violence, child abuse, and neglect.² It is an evidence-based, cognitive behavioral support group model that aims to increase resiliency and decrease risk factors, integrating addiction recovery concepts with family living skills.

CF! and Strengthening Families™ programs have overlapping goals: providing education and skill building to families who have been impacted by the problems noted above and by substance use disorders. Neither program was developed with a specific focus on families affected by substance use disorders. They are both unique in their emphasis on building strengths rather than identifying weaknesses. The two programs originated in different ways. Strengthening Families™ was developed with a clinical focus, with an initial focus on children. The early articles describing the program provided measures and discussion

² See www.celebratingfamilies.net.
that were clinical in perspective. CF! on the other hand, although also developed by mental health professionals, developed as a program that was more family-focused, with outcome measures that were family ratings of the program. EBCRP chose to implement CF! because it had been developed on family groups that were very similar to the families in our programs: mothers who were women of color with few educational or occupational resources, and who carried the burden of extensive histories of abuse and violence.

Participants in CF! include the mother and child (or children) in residence, grandparents, friends, aunts and uncles, siblings, and other supportive individuals in the mothers’ lives. It focuses on family-centered treatment practices and is a multifamily/multigenerational event. CF! is the only evidence-based family program for families involved in substance abuse listed in SAMHSA’s National Registry of Evidence Based Programs and Practices (NREPP). Although no controlled trials have been published as yet, NREPP summarizes the available evaluation data used to qualify it for inclusion on its list of evidence-based practices (see http://www.nrepp.samhsa.gov/ViewIntervention.aspx?id=100).

CF! sessions are provided weekly over 16 weeks, enabling all residents and their identified extended family members to attend. Each session of CF! is a three and a half hour program which begins with a family meal followed by subgroup programming for adults, children and adolescents, with age-appropriate materials. Following the family dinner, participants attend a 90 minute instructional session on the following themes: (1) healthy living; (2) nutrition; (3) communication; (4) feelings and defenses; (5) anger management; (6) facts about alcohol; tobacco, and other drugs; (7) addiction as a disease; (8) the effects of addiction on the whole family; (9) goal setting; (10) making healthy choices; (11) healthy boundaries; (12) healthy friendships and relationships; and (13) individual uniqueness. Parents then reunite with their children for a 30-minute activity to practice what has been presented and learned and to receive feedback on their performance (see http://www.nrepp.samhsa.gov/ViewIntervention.aspx?id=100).
Mothers in Project Pride are carefully assisted in identifying family, friends, partners, and significant others who are, or can become, part of a positive, safe, and supportive community for the women when they leave treatment. CF! sessions generate trust and excitement, enabling staff to expand their intervention efforts. CF! began at Project Pride as a voluntary program, 44 of the 53 residents since it started have participated. A broad definition of “family” is encouraged. To date, of the 44 resident participants, 12 of their mothers and 8 of their fathers have participated, as well as 10 sisters and 3 brothers. Additionally, 10 partners, husbands, or biological fathers of the children have participated, along with 49 children of the mothers who were not in residence at Project Pride. Some families have driven as far as 110 miles round trip to participate. Each of the family members who attended was contacted by the family therapist, interviewed, and offered support, referrals, and information as needed. At six-month follow-up, 96% of residents reported that they had support from family and friends.

Implementing CF! in Project Pride contains elements of a prevention strategy since many family members are at high risk for child abuse, as well as an intervention strategy since the program provides direct treatment to children who are trauma survivors.

**Integrated Case Management to Strengthen Protective Factors**

The second change made to the program was to build an Integrated Case Management Model that would be unique for each woman in treatment. Previously, the woman received case management services as needs emerged. The transition involved forming a team of internal staff and external providers, starting as early as possible after admission and meeting together as needed to coordinate treatment plans and services.

Two different types of meetings facilitated the goals. Administrative meetings focused on general coordination of services, information, and resources, and provided an opportunity to share perspectives. Meetings with the resident and her family focused on encouraging steps towards specific goals. The overall aim was to provide wraparound services that met the resident’s needs at a given point in time. Working with outside
agencies also gave the resident a better understanding of how to tap community resources and offered practice while she was still in treatment. In some cases, important relationships were initiated with a representative from specific outside service providers. Developing and maintaining these collaborative interactions was no easy task. While all meetings included the County Department of Family Services, other participants included Children’s Hospital Oakland Infant Mental Health Program, the Department of Public Health, program specialists from Services to Enhance Early Development (SEED), and Early Head Start.

Meetings can be convened at the request of the mother, a family member, or another member of the team when a court date is scheduled or a new situation arises. It can include the child welfare worker, parent advocate, SEED worker, and family members who are appropriate. This team focused on the woman and child in residence and also on meeting the needs of the mother’s other children whenever possible.

Enhancement of protective factors required multiple resources. The Integrated Case Management Model makes it possible to match diverse client needs with appropriate forms of assistance. A tight matching strategy, such as the Integrated Case Management Model, has been documented to improve reunification (Smith & Marsh, 2002). Project Pride teamed up with a number of community and other agencies for core services that we needed, such as health care, mental health, and housing, to provide comprehensive, family-focused assessments and services. These collaborations encompassed mothers, children, and other family members not living in Project Pride who were included in the meetings when appropriate. These meetings occurred with greater frequency at the beginning of treatment, and when the mother was about to graduate from the program, to further help her and her family renegotiate their relationship if needed. Meetings occurred weekly, monthly, and ad hoc to ensure that all the professionals involved had the opportunity to contribute and benefit from the collaboration.

A focus on children’s safety necessitated attention to substance abuse and child abuse prevention, education, and treatment for the mother. When past abuse is identified, treatment is offered or arranged. However,
the program went beyond this in building an environment that helped residents to develop their own protective factors.

In addition, Project Pride mental health staff worked with family members who were not in residence (e.g., the mothers’ parents, siblings, children that were not in the residential program) to make referrals for needs they identified including mental health and/or substance abuse treatment, housing, and job training. Staff also offered couples and family counseling. These additional counseling services helped ease the transition of the young family into the community maintaining the protective factors developed during their stay in the program.

In implementing these changes, EBCRP observed the following benefits for participants:

a) Children participants in Project Pride, including those in CF!, benefited from being provided with stability, safety, and the opportunity to grow up in a family that was actively supporting their healthy growth and development. Any social, emotional, or health-related deficits were identified and appropriate interventions were recommended, and staff could follow up while the mother was in the program as part of their integrated case management plan. A goal of the project was to end the intergenerational transmission of trauma. Since the children typically spend time being cared for by extended family members, increasing the protective factors in the extended family increased their safety. In addition, an unknown number of children who are part of the extended family (e.g., cousins) similarly benefitted from their caregivers’ participation in CF!.

b) Mothers benefitted from participating in treatment with family members of their choice that included partners, parents, siblings, grandparents, friends, and other extended family members. The CF! program aimed to increase the resiliency of all participants, strengthen their family and social connections, and decrease their isolation. They benefitted from increased understanding of substance abuse and its impact on families, trauma and its impact on parenting, and the impact of abuse on their child’s development.

c) Family members benefitted from increased understanding of the needs of their children and other relatives. They gained access to family, couples, and
co-parenting counseling to address complex issues and increase their access to other services they may need. They gained an understanding of how treatment can help their family to set and achieve healthy goals, and

**Figure 1**

**Specific Activities to Develop Protective Factors**

<table>
<thead>
<tr>
<th>PROTECTIVE FACTORS</th>
<th>Family Functioning/Resiliency</th>
<th>Social Support</th>
<th>Concrete Support</th>
<th>Child Development/Knowledge of Parenting</th>
<th>Nuturing and Attachment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Parenting Group</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Child Enrichment</td>
<td>X</td>
<td>X</td>
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<td>X</td>
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<tr>
<td>Team Meeting</td>
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<td>X</td>
<td></td>
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<tr>
<td>Celebrating Families!</td>
<td>X</td>
<td></td>
<td></td>
<td>X</td>
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<tr>
<td>Early Head Start/Head Start</td>
<td>X</td>
<td>X</td>
<td></td>
<td>X</td>
<td></td>
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<tr>
<td>Library Trips/Zoo Trips/Other Outings</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Mommy and Me Group</td>
<td>X</td>
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<tr>
<td>Bodies in Motion Group</td>
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<tr>
<td>Community Awareness</td>
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<tr>
<td>Healthy Connections Group</td>
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<tr>
<td>Home Groups</td>
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<tr>
<td>NA/AA</td>
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<td>DBT</td>
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<tr>
<td>Seeking Safety Group</td>
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<td>X</td>
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<tr>
<td>Mom+Child (Dyadic), Co-parenting/Couples Therapy, Family Therapy</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
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<tr>
<td>Relapse Prevention Group</td>
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<td>Anger Management</td>
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<td>Domestic Violence Group</td>
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<tr>
<td>Vocational Training</td>
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</tbody>
</table>
increased their capacity to end the intergenerational cycle of trauma. In
addition, some deeper family wounds were addressed, which further sup-
ports the resiliency of the family. Weekly group activities with other fami-
lies who share similar difficult experiences reduced stigma and shame.

Figure 1 provides a snapshot of the components of the program and
illustrates the activities through which protective factors were enhanced.
Project Pride programming is listed in the first column and the protective
factors that are part of the activities are shown in the subsequent columns.

The chart documents that residential treatment for mothers and their
children offers multiple opportunities to strengthen protective factors
in an integrated treatment model. Some of the CSSP protective factor
labels were adapted to be more specific to the residential setting.

Outcomes

Highly structured residential treatment for mothers with children are
not common, but they share a commitment to improving two outcomes
that funders seek: increasing retention in treatment and reunification
with children. Funding provided through a SAMHSA grant allowed
for providing performance measures; however, a research design with a
comparison group was not required by the grant or conducted. The out-
comes collected and described here were focused on improvement in
retention in treatment and reunification of children with their mother.
Specific outcomes, in addition to those mentioned above, include gains
in the protective factors of the mothers, gains in communication and
support by extended family members, and the engagement of family
members in further clinical services.

The SAMHSA grant also provided a staff position to develop the CF!.
When CF! began, some women were eager to join, while others were not.
That was the only time period when a comparison group of non-equivalent
Project Pride residents was available. Project Pride now encourages all
residents to participate in CF!. Figure 1 reflects the program activities
focused on developing the protective factors. The data on the specific pro-
tective factors is now being collected, but since all of the women who are
being assessed are still in the program, outcome data is not yet available.
A comparison of outcomes of the 44 women who participated in these two supportive interventions to 51 women who were in Project Pride but did not take part in the interventions showed improvements in several measures of recovery. Data were obtained using the Mental Health sections of the Government Performance and Results Act, or GPRA (see http://www.samhsa.gov/grants/gpra-measurement-tools). These included self-reports of mental health symptoms: only 41% ($n = 21$) reported having experienced psychological or emotional problems in the last 30 days, compared to 78% ($n = 40$) who reported such problems when they entered the program. Reductions in self-reported risk behaviors were also apparent at six-month follow-up, compared to intake. These included fewer reports of any drug or alcohol use in the past 30 days (43% at intake vs. 6% six months later). Regarding increased program retention, women who participated in the enhanced program remained in treatment for an average of 206 days, compared to 128 days for women who did not participate. Equally important, reunifications approached 100%, partly because Family Court and Child Protective Services staff learned of both progress toward recovery during the integrated case conferences and family support that would be continuing after discharge. Project Pride staff also reported that the CF! program led some families to realize that other family members also needed mental health and/or substance abuse treatment, and many of these family members have been served by other EBCRP programs.

**Figure 2**

**Comparison of Outcomes**

<table>
<thead>
<tr>
<th>Measures</th>
<th>Intervention Group</th>
<th>Services as Usual</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Baseline</td>
<td>Discharge</td>
</tr>
<tr>
<td>Self-reported psychological problems</td>
<td>78%</td>
<td>41%</td>
</tr>
<tr>
<td>Drug/Alcohol use in prior 30 days</td>
<td>43%</td>
<td></td>
</tr>
<tr>
<td>Length of Stay</td>
<td>206 days</td>
<td>128 days</td>
</tr>
</tbody>
</table>
Discussion

Concepts from the program spread throughout Project Pride. Staff members reported observing positive language and skills learned in the groups, and even more importantly, supportive behavior and communication being used to help recovery within and between families. Similarly, women are sharing information about their experiences in Integrated Case Management meetings. Focus groups held with consumers indicated that the women and family members were enthusiastic about these additions. Several successful graduates from Project Pride requested to continue attending CF! even after discharge, and their stories provided additional examples of success to current program participants.

This report does not provide sufficiently complete outcome data for readers to assess what may have helped some mothers and families to do so well. The intent of this manuscript is to report a promising change that allows families to work together to build strong protective factors. The field may use this preliminary information, but specifically the testing of the Strengthening Families™ protective factors framework with a group of mothers with substance use and mental health needs is warranted. The program changes are working for the residents who report during the focus groups that they have something positive to look forward to each week and are partnering with family members to build better communication and support one another.

As the enhanced program continues, Project Pride will continue to measure gains made in fostering resilience, social connectedness, and family support. Specific outcomes, in addition to those mentioned above, will include gains in the protective factors of the mothers, gains in communication and support by extended family members, and the engagement of family members in further clinical services. Evaluation will also analyze the “dose” effect of CF! participation to see whether women who participated in more than the median number (10) of sessions had better outcomes than those who attended fewer than the average number of sessions.

Residential treatment is expensive, and there is always pressure from funders to reduce the length of stay to provide more access. Hopefully future research can continue to document the benefits of adequate
treatment, especially with sufficient length of stay, through long-term follow-up of the mothers and their children.

Programs for mothers and their children exist across the country, and it is to be hoped that child welfare workers are aware of those that exist in their communities. It is important to establish or strengthen collaboration, and to encourage the development of a strong program for family members. The enhanced Project Pride program represents a powerful opportunity to work on strengthening the protective factors that support long-term recovery and effective parenting, not only for the residents, but for the family as a whole.

Conclusions

When working with families with multiple challenges, it can be difficult to maintain a strength-based focus. Frequent crises and numerous practical obstacles often consume staff attention. Project Pride staff found that it was useful to work with family members who were not in residence together to identify opportunities for strengthening the family’s protective factors and generate strategies and activities to foster their goals. When women and their children are together in a residential treatment setting, this creates unparalleled opportunities for therapeutic intervention, both in specific treatment activities and in the teaching, modeling, mentoring, and reinforcement moments that occur in everyday life. Bringing family members into the recovery process increases these opportunities. This modality, possibly unique to substance abuse treatment, has fulfilled much of its promise. Hopefully, future research will increase understanding of the role these factors play in recovery and ways to strengthen them in residential and other treatment settings.

References


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- Fy ending 9/30/05      5 H79TI16005-01
- Fy ending 9/30/06      5 H79TI16005-02
- Fy ending 9/30/07      6 H79TI16005-03
- Fy ending 9/30/2010    1 H79TI019577-01
- Fy ending 9/30/2011    5 H79TI019577-02
- FY ending 9/30/2012    5 H79TI019577-03 (Extended to 5/31/13)

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