The Haven Mother’s House Modified Therapeutic Community: Meeting the Gap in Infant Mental Health Services for Pregnant and Parenting Mothers with Drug Addiction

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ABSTRACT: The specialized needs of pregnant and parenting women in the treatment of drug addiction must not be underestimated. The impact of substance abuse on developmental outcomes for young infants and children supports the notion that attention to the parent-child relationship is a critical aspect of addiction treatment for this population. As such, the standard of care appears to be shifting from separating mothers and young children while the mother completes addiction treatment to women residing with their children while in treatment and receiving concurrent addiction treatment and parenting education. While parenting education is important, it may not provide the needed relationship intervention to address the myriad of issues often present for female recovering addicts and their children. This article describes the evolution and workings of a program for integrating infant mental health practice into a long-term residential treatment community for pregnant and parenting women with addiction. The principles and structure of the modified therapeutic community are described, as well as the ways in which infant mental health practice have been effectively integrated and incorporated into the addiction treatment philosophy. A case example is provided and clinical implications are discussed.
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Despite the growing body of literature outlining a range of deleterious effects of substance abuse for women and their children (see Pagliaro & Pagliaro, 2000, for review of the teratogenic effects of prenatal substance exposure), substance abuse among pregnant and parenting women appears to be an unremitting societal problem. For many infants of drug-addicted women, prenatal drug exposure involves not only multiple licit and illicit substances, but also the environmental sequelae of addiction. Studies indicate that environmental influences concomitant with substance abuse may have a larger impact than drug exposure itself (Kim & Krall, 2006). These influences involve extremely poor nutrition, poor if not non-existent prenatal and general medical care, and unpredictable living arrangements.

Substantial evidence also links a myriad of relationship issues, including poor parenting capacity of caregivers, lack of caregiver availability, troubled family relationships, and increased potential for abuse (Camp & Finkelstein, 1997; Finkelstein, 1994; Lester, Boukydis, & Twomey, 2000; Nair, Schuler, Black, Kettinger, & Harrington, 2003) to substance abuse and deprived environments. The frequency of child abuse and neglect, placement of children outside the home, and parenting attitudes indicate that children of substance abusing parents are more likely to be victims of child abuse and neglect, be removed from their home, and experience harsh parenting (Bauman & Dougherty, 1983; Kelleher, Chaffin, Hollengerg, & Fischer, 1994; Tyler, Howard, Espinosa, & Doakes, 1997). Some studies, but not all (see Beeghly, Frank, Rose-Jacobs, Cabral, & Tronick, 2003; Seifer et al., 2004) show that these children are also more likely to have insecure or disorganized attachment patterns (O’Connor, Sigman, & Brill, 1987; Rodning, Beckwith, & Howard, 1989) and less than optimal parent-child interactions. For example, mothers who use cocaine prenatally are less
sensitive, more intrusive, and less responsive to their infants, infants demonstrate poorer clarity of cues, and there is increased conflict within mother-infant dyads (Burns, Chethik, Burns, & Clark, 1991; Eiden, 2001; Mayes et al., 1997; Minnes, Singer, Arendt, & Satayathum, 2005). Mothers of prenatally cocaine-exposed infants also display more negative interactions with their infants (Tronick et al., 2005).

As a result of the increased risk for these mother-infant dyads, it may be necessary to provide intensive parenting intervention as part of substance abuse treatment. Benefits of prevention and intervention policies and programs focused on family-centered treatment for substance abuse, with specialized attention to the needs of women and children together, are considerable (Lester et al., 2000; Schuler, Nair, & Harrington, 2003). Studies examining parenting components of substance abuse programs continue to point toward the integration of parent training as an essential component of successful treatment (e.g., Camp et al., 1997). While necessary, parent training alone may not be sufficient to provide the education, support, and intervention needed for mothers struggling with addiction and parenting children prenatally exposed to drugs of abuse. Historically, women have needed to separate from their children in order to participate in intensive substance abuse treatment. In increasing instances, care is shifting towards women and their children residing together in residential treatment, allowing the mother to receive needed addiction treatment while simultaneously managing the demands of parenting. The services provided to the mother-child dyad surrounding parenting education and support varies across addiction treatment facilities. However, the availability of intense infant mental health services to these dyads is still rare, despite increased recognition of the importance of early identification and treatment in this population.

This paper will discuss the conceptual foundation and evolution of a unique residential addiction treatment facility designed specifically to meet the needs of pregnant and parenting women
and their young children. It involves the collaboration between a modified therapeutic community addiction treatment facility and an infant mental health program that has resulted in integrated care for pregnant and parenting women in residential addiction treatment. The evolution of this program will be described, with a focus on the integration of infant mental health care as part of addiction treatment as best practice for this population. A case example and clinical implications are provided.

**Therapeutic Community Treatment**

The Therapeutic Community (TC) model of addiction treatment has been widely recognized as an effective means of treating substance abuse and criminality, particularly for underserved populations, those with severe addictions, and/or individuals mandated for care by the justice system. Born out of substance abuse programs established within psychiatric hospital settings in the 1950’s, the term therapeutic community generally refers to comprehensive residential treatment for the many problems associated with drug and alcohol dependence (De Leon, 2004).

Therapeutic communities have been distinguished from other modalities of substance abuse treatment by their comprehensive range of interventions provided within a single setting and an emphasis on the community itself as primary therapist (Eliason, 2006). The treatment is a peer-to-peer intervention where clients are responsible to both to themselves and one another, with group consequences for individual behavior and positive “peer pressure” and confrontation (i.e., “in your face”) as central principles of treatment programming.

As De Leon (2004) describes, the overarching goal of treatment is to establish skills to maintain a drug-free way of life. The phases of TC programming are progressive in nature, with movement through stages of treatment analogous with that of a developmental model. The initial phase of the TC is known as Orientation. The Primary Treatment phase follows Orientation and lasts anywhere from 10-12 months. The stages within this phase of treatment are again progressive, and
Gender Issues in the Therapeutic Community

Gender issues in substance abuse treatment have received increasing attention over the past few decades. There is a substantial literature attesting to gender-specific differences across the many phases and facets of addiction, including heritability, biological, psychological, and behavioral correlates (e.g., risk taking behavior), as well as differences with regard service utilization from identification of substance use, treatment access and initiation of care, engagement, retention, and relapse (Agrawal et al., 2008; Best et al., 2008; Green, 2006; Lynch, 2006; Sarin et al., 2008). The prevalence of substance use in the prison population is substantially greater than that of the community population, and this is especially so for women (Fazel et al., 2006). Because many referrals to the highly structured TC come from the correctional system, attention to gender-specific differences in the prison population are particularly relevant when examining gender issues as related to the need for specialized programming in the TC. For example, as compared to male counterparts, female offenders are more likely to struggle with depression, anxiety, posttraumatic stress disorder (PTSD) and histories of physical and sexual abuse (Lewis, 2006; Peters et al., 1997), where distressing symptoms can be
easily activated or triggered by confrontational TC approaches. Many women who find themselves in the criminal justice system are involved in substance abuse/criminal activity as a result of involvement with a substance-abusing partner. One factor that seems particularly pertinent is the role of spouse/partner relationships and the impact of domestic violence on substance abusing women. For these women, if the maladaptive relationship patterns and domestic violence are not specifically addressed in treatment, there is a high probability that they will return to their abusive partner following treatment, remain victims of violence, and soon relapse (Eliason, Taylor, & Arndt, 2005; Martin, English, Clark, Cilenti, & Kupper, 1996). Thus, women’s family histories, substance abuse, physical, emotional, and sexual abuse, as well as trauma related to domestic violence, render some women too fragile for conventional, confrontational TC approaches (Anglin, Hser, & McGlothlin, 1987; Bersak, 1990; Coletti et al., 1995; Eliason, 2006; Gomberg, 1993; Grella, Joshi, & Hser, 2000; Jarvis, 1992; Miller & Downs, 1993; Namyniuk, Brems, & Carson, 1997). Careful consideration of the important role of relationships is essential when treating women who struggle with addiction, with attention to their roles in family relationships and relationships with partners as required for comprehensive and effective treatment (Rubin et al., 1996, McKay et al., 1996).

The Haven Modified Therapeutic Community

The Haven Modified Therapeutic Community (MTC) opened its doors to meet the need for specialized residential addiction treatment for women in 1992. Operating as part of the Addiction Research and Treatment Services (ARTS) in the Department of Psychiatry at the University of Colorado Denver, The Haven provides a stable, safe, and drug-free environment that facilitates the ability of the female clients to overcome behaviors that led them to a lifestyle centering on substance addiction. Clients are given an opportunity to learn alternative ways to cope with their feelings, understand the negative consequences of addiction, and are taught how to make appropriate and
healthy choices for themselves. The mission of the Haven is to maintain principles of the TC, with particular focus on gender-specific issues known to impact women who abuse substances.

Typical for TC populations, Haven women are admitted from the county jail or Department of Corrections, were previously homeless, and/or are referred by the Department of Human Services. A small proportion of clients are self-referred. All of the clients treated at the Haven have a severe, chronic addiction to substances, most typically methamphetamines, cocaine, or heroin. Approximately 60% to 80% have a co-occurring mental health disorder. In addition, approximately 5% of the clients have a developmental disability. Residential treatment typically lasts from approximately 9-12 months.

Women residents adhere to a regimented schedule each day and participate in structured group-activities beginning at 7:00 a.m. and lasting until approximately 10:30 pm. Treatment activities address recovery from addiction using a range of behavioral and cognitive-behavioral techniques, with concurrent and integrated services targeting those mental health issues requiring individualized care. Treatment activities include individual and group education and counseling, peer-run activities, groups, meetings, vocational skills, GED preparation classes, as well as on- and off-site 12-step meetings.

Specific efforts are made to tailor all interventions to the specific needs of women, many of whom have been victimized and traumatized but do not necessarily meet criteria for PTSD. For example, one core piece of programming that is mandatory for every Haven woman is the use of the Seeking Safety curriculum (see Najavits, 2007), an evidence-based curriculum designed for the integrated treatment of trauma and substance abuse. For those women who do meet criteria for PTSD or who have particular triggers associated with their histories of abuse and victimization, appropriate modifications to therapeutic community interventions are also designed and implemented. For
instance, in a typical TC, confrontation about a particular behavior is forceful and intentionally loud and intimidating to grab the attention of the client being addressed, with points about a client’s criminal and addictive behavior being overstated and exaggerated during the confrontation. The client is required to stand silent in front of the peer or staff member during such confrontation and is not permitted to respond at that time. For women with histories of trauma and particularly domestic abuse, such an approach can be perceived as aggressive and threatening, and can trigger a number of unhealthy trauma responses. At the Haven’s MTC programs, confrontation is modified to be monotone in nature, with balance between commentary to clearly address the behavior and a style that can be safely interpreted by the client as both firm and therapeutically supportive.

Interventions include a clear focus on relationships, with the understanding that treatment for this population must be both trauma-informed and relational in nature in order to be effective. Thus, the notion that relationships and affiliations in the MTC mimic those outside of the walls of the residential facility permeates thinking and development of relational interventions, with attention paid to peer relationships, relational responses to staff, and a client’s general ability to form and maintain healthy connections during their treatment stay. A client’s relational ability is most definitely linked to likelihood of relapse and, as such, it is present as a treatment goal from the earliest phase of care, with sustained efforts to target relationship-based issues throughout the duration of rehabilitation. In addition to individual treatment interventions focused on relationships, at the Haven programs, once a client is in the appropriate phase, women participate in specific groups designed to address those particular difficulties that contribute to patterns of victimization and abuse (e.g. co-dependence as a specific topic of “Relationship Group”), and then again have an opportunity to attend another on-site MTC group with their significant others and family members as they begin to transition back into the community and reunite with loved ones. This allows for continuity of care and attention to relationship
issues as an integrated part of residential care within the safe and supportive confines of their treatment home, often the only place they have practiced healthy affiliations and connections to others in their lifetime. From the start of treatment, women are encouraged to invite their children to visit with them during Kids Day, a consistent time that is set aside each Sunday for children to visit with their mothers in residence under staff supervision in an attempt to begin to rebuild parenting relationships that have been negatively impacted by the consequences of addiction.

Case management services are also part of the treatment regimen, and the women are linked to services such as healthcare, dental care, transportation, vision care, employment, and vocational services. Additional collaborations include those such as Department of Human Services (child welfare/social services, Temporary Assistance for Needy Families), Department of Corrections (parole), probation, community healthcare providers for substance abuse treatment, the Alcohol and Drug Abuse Division, and the Department of Criminal Justice.

Mothers and Babies in Treatment

There are significant and specific barriers to women’s substance abuse treatment related to mothering, with mothering women generally being underrepresented in drug treatment and proportionally overrepresented with regard to poor completion rates, often directly related to motherhood status (Finnegan, 1988; Grella et al., 2000; Scott-Lennox, Rose, Bohlig, & Lennox, 2000; Sutker, Patsiokas, & Allain, 1981). Mothers with drug and alcohol abuse problems often avoid seeking treatment altogether or provide inaccurate drug histories to medical practitioners for fear of judgment by professionals, stigma, fear of punitive consequences including separation from children, and an overwhelming sense of fear and guilt related to consequences of their drug use on their children. This is particularly true for those who abuse substances during pregnancy. Thus, effective treatment of this population requires attention to women’s addiction treatment needs in the context of their mothering
role. Further, it is estimated that 70 percent of women who do enter treatment have children who are at increased risk of abuse, neglect, developmental problems, and development of substance abuse themselves as a consequence of parental addiction (Werner, Young, Dennis, & Amatetti, 2007). With the increase in knowledge about the growing addiction treatment need for pregnant and parenting women amidst scarce resources and public awareness of and demands for treatment for this population, the Haven committed to admit pregnant women and mothers with their infants as residents of the program and was the first program of its kind in Colorado to do so.

The challenges of meeting the demands of pregnant and parenting women within this specialized women’s program quickly emerged. Were the typical gender-specific modifications to conventional TC approaches enough to adequately meet the needs of those pregnant and/or parenting? What about the specific needs associated with pregnancy and appropriate care for the infants living in residence? Was it possible to effectively balance demands of a MTC milieu with pregnancy and parenting demands without sacrificing addiction treatment success? Is it appropriate for young infants to be exposed to the methods of the TC that are critical to the core of the milieu? Is the “culture” of pregnancy and parenting in addiction treatment different from that of women without infants in residence? And what about the babies?

Addiction treatment literature has demonstrated the feasibility of adapting TC treatment methods to increase TC’s capacity to serve special populations without sacrificing core principles considered critical for treatment success (e.g., Sacks et al., 2004). In fact, the existing literature points to features of the TC that may be remarkably fitting for mothers in treatment with their children. Egelko, Gallanter, Edwards, and Marinelli (1996) write of the “holding environment” experienced from the clear behavioral guidelines and consistent discipline of the TC as a model for appropriate parenting which may have been absent from women’s own lives. In their model MTC program for
substance abusing pregnant and parenting women in residential treatment, Pajulo, Suchman, Kalland, and Mayes (2006) posit the importance of an opportunity for practicing skills necessary to meet the demands of motherhood as an integrated part of addiction treatment. They suggest an emphasis on enhancing the mother-child relationship as a central focus of addiction treatment for parenting women. Others highlight early motherhood as a time when mothers with substance abuse problems appear to be particularly motivated to use intensive support (Crittenden, Manfredi, Lacey, Warnecke, & Parsons, 1994; Pajulo, Suchman, Kalland, & Mayes, 2006).

Benefits of attending to motherhood as part of successful substance abuse treatment programming are persuasive. Parenting education and strengths-based family preservation are crucial to improved caregiving and decreased incidence of child abuse and neglect (Namyniuk et al., 1997), and to improvements in emotional availability, affective attunement, and positive dyadic interaction between mother and baby (Burns, Chethik, Burns, & Clark, 1997; Lief, 1985). Better outcomes occur when services are specialized to target women’s needs and/or mother and baby remain together over the course of treatment, often leading to improved treatment retention, which is linked to higher levels of posttreatment abstinence and decreased recidivism rates (Glider et al., 1996; Grella et al., 2000; Szuster, Rich, Chung, & Bisconer, 1996; Weisdorf, Parran, Graham, & Synder, 1999). As satisfying relationships develop between mother and child, posttreatment abstinence rates improve, resulting in long-term benefits for mother and child as the relationship helps to reorganize the addictive reward system from reliance on substances to the positive associations of the relationship with baby (Collins, Grella, & Hser, 2003; Pajulo et al., 2006). Further, when families are permitted to remain together and treatment is family-centered in its focus, outcomes extend to include improved parenting and overall family functioning, increases in the numbers of families reunified or remaining intact, and improved social and economic outcomes as families become increasingly productive contributors in their
communities and utilize less resources and public service-delivery systems (Werner et al., 2007). From an intergenerational perspective, it is known that children of substance abusing caregivers are at higher risk for abuse and neglect as well as developing substance use disorders themselves (Price & Simmel, 2002; Werner et al., 2007; Young, Gardner, & Dennis, 1998). With treatment focused on the specific needs of families, risk factors decrease and protective factors improve, rendering the children of these families less likely to abuse substances and reap the benefits of improvement in overall health and safety. Moreover, residential programs with greater numbers of pregnant and parenting women have been recognized as having more service-enriched, family-focused environments, and better, more positive therapeutic relationships (Grella et al., 2000), factors known to contribute to improved treatment outcomes. With this knowledge and evidence that treatment of perinatal addicts appears most successful when begun prior to delivery (Egelko, Galanter, Edwards, & Marinelli, 1996; Namyniuk et al., 1997; Pajulo et al., 2006), the admission of pregnant and mothering women was a theoretically logical and empirically supported extension of the residential treatment model at The Haven, with efforts made to admit women as early in pregnancy as feasible.

The Haven Mother’s House

Within months of incorporating the admission of pregnant and parenting women into the Haven’s modified treatment milieu, it became clear that successful treatment for this population would require yet further modification specifically tailored to the demands of pregnancy and parenting. First and foremost, there was a need for a separate physical space to accommodate the infants living in treatment with their mothers. For example, a typical residential room at The Haven houses four clients, often set up with 2 sets of bunk beds parallel to one another. The addition of even one crib often created cramped quarters for residents and required that mothering women receive the “privilege” of the bottom bunk to attend to a crying child in the middle of the night, a right previously earned based
on positive behavior in the MTC. With the addition of several highchairs in the community dining space, changing tables in the restrooms, appropriate and accessible places to store diapers, wipes, and developmental toys, it soon became apparent that the babies were not simply going to “fit in” to the existing physical space and significant changes were necessary.

Secondly, and even more significantly, the need for consultation from those with expertise in parenting and infant needs surfaced as an almost immediate clash between typical MTC programming and the demands of parenting emerged. Specifically, there was a need for program development centered on the challenges associated with balancing the seemingly conflicting demands of addiction treatment and family-centered care. This new “culture” of pregnancy and parenting in residential addiction treatment was in fact quite different from that of those women living in residence without their children and required specialized attention. For instance, in the same way that the traditional loud TC confrontation described above is deemed inappropriate for women with trauma, this kind of “in your face” intervention is an inappropriate practice from an infant mental health perspective. Despite modifications, implementing the modified version of this type of intervention while a client is holding her baby in her arms is still inappropriate from an infant mental health perspective, as the infant can unnecessarily experience stressors related to the intervention and such interventions are best conducted outside of the infant’s environment. Or, MTC treatment can involve long hours, at times disrupting sleep or delaying bedtime to achieve a behavioral substance treatment goal. This was problematic for infants, who were disturbed during their sleep so that their mother could engage in necessary treatment interventions. Expert infant mental health consultation to the MTC was required not only for the mothering clients, but also for the staff, who were well trained in addiction but came to the treatment milieu with little or no training in parenting or infant care and were now unprepared to face daily challenges of adapting the culture of the milieu to accommodate such needs.
The environment was ripe for consultation around the clash of cultures (i.e., parenting vs. MTC) at the Haven. Fortunately the attending addiction psychiatrist, Dr. Robert Harmon, M.D., who provided medication consultation for the women in treatment, was also the director of an infant mental health program (The Harris Program in Child Development and Infant Mental Health program at the University of Colorado Denver School of Medicine). With the investment and vision of the Haven’s director who understood the need for modifications toward successful integration of pregnancy and parenting in a therapeutic community milieu setting, a partnership and ongoing collaboration between The Haven MTC and the Harris Program was launched. Together, the director of the milieu and Dr. Harmon pioneered an effort to bring consultation and treatment specific to infant mental health practice to the Haven, challenged to strike a fragile balance of adapting Haven MTC treatment programming with the specific needs of women and infants without sacrificing the inherent/core elements of addiction treatment. A series of ongoing modifications were instituted, beginning with the recognition of an undisputed need for a separate physical space to accommodate infant care/needs. In September 2004, the Haven Mother’s House Program opened its doors as a distinct residence to treat pregnant and parenting women.

The Haven Mother’s House mission is to provide safe and empowering MTC treatment for pregnant women and their infant children. The same Haven emphasis on goals toward recovery from addiction and integrated and comprehensive care for the many issues involved in substance abuse are present (as described above), along with tailored opportunities to deliver healthy, drug-free infants, and become self-sufficient, confident, and productive caregivers. Distinct from the Haven, the Haven Mother’s House strives to interrupt the intergenerational pattern of substance abuse to positively impact both the mother and her children’s quality of life with an integrated focus on parenting clean and sober. While many of the women at the Haven Mother’s House are not first-time mothers, their
experience parenting at the Haven Mother’s House is often the first while not using substances. The Haven Mother’s House operates with the philosophy that it is critical that a mother be with her infant as she progresses through treatment. The children are the heart of the program and allow the mother to experience motherhood in a substance-free environment, usually for the first time in the woman’s life. Treatment focused on motherhood is as central to addiction treatment as the principle of abstinence from substances itself. Whereas early programs considering the needs of parents and children have treated pregnancy or parenting services as supplementary with such services as separate or “outside” of the addiction treatment itself (Grella & Greenwell, 2004; Kumpfer, 1991), the Haven Mother’s House serves as a rare model in its successful integration of pregnancy and parenting services into the very core of the program. The physical space at the Mother’s House is organized with mother and baby in mind, with room for 4 adult beds and 4 cribs per room, each decorated as a nursery. Bathrooms and bedrooms are equipped with changing stations, there are rocking chairs for nursing mothers, a family room where children can play together with their mothers, tables set up for mealtime where baby can sit comfortably in a highchair beside mother, and clients and staff are continually responsible to be sure the house is safe and baby-proofed for mobile babies. As is true at the Haven, there is careful attention paid to all relational issues, with an additional and often concrete focus on the parenting relationship between mother and child. Coupled with an understanding of the psychological amenability that often accompanies pregnancy and motherhood, this setting provides an extraordinary opportunity for the delivery of infant mental health services and relationship-based parent-infant intervention in a MTC setting that might otherwise feel impenetrable to this kind of service delivery.

The Haven Mother’s House provides residential substance abuse treatment to a diverse group of adult women who reside with their infant children. The adult women typically range in age from 21 years to 40, with an average age of 26 years. Nine percent of women identify as African American,
13.6% as Mexican, 13.6% as Hispanic, and 63.6% Caucasian, and all qualify as TANF (Temporary Assistance for Needy Families)-eligible, low-income individuals. Approximately 32% of the mothering women in residence have the participation/presence of partners during their treatment stay, with the other 68% identifying as single mothers. Women enter the program in various stages of pregnancy or with a newborn infant in their custody, with babies’ ages ranging from newborn to 18 months and the majority of infants in residence 12 months and younger. Admission criteria match those of the Haven, and women are admitted from the same referral sources described earlier. In contrast to the typical length of stay at The Haven, the average length of stay at The Haven Mother’s House is between 12-15 months, with rare cases of extended treatment stays attributed to complications related to mother’s psychiatric status, developmental delays, or other special needs. In general, the additional time spent for all mothers (i.e., 12 to 15 months) in residential care is often due to parenting demands that require the women be out of the residential house during treatment (e.g., prenatal appointments, hospitalization for labor and delivery, WIC appointment, well-child check-ups, doctor’s appointments for sick children), resulting in a comparatively slower progression through the phases of treatment.

Located just a few buildings away from the Mother’s House on the same block, the on-site daycare provides childcare for the Haven Mother’s House infants. The daycare staff’s philosophy as childcare providers is to support mothers to strive towards enhancing their children’s physical, emotional, and cognitive growth. In order to allow mothers to attend treatment groups, the daycare is open from 8:00 a.m. to 4:00 p.m., with opportunities for mothers to be with and feed their infants during lunch as part of programming. During this time, mothers may receive nutritional guidance from staff and are able to meet individually with daycare staff to address concerns and receive parenting support. The daycare staff members assist each child in meeting his/her developmental milestones and
receive consultation as needed from the Harris program’s on-site infant mental health specialists for interactions that seem problematic or require more specialized attention.

A typical day at the Haven Mother’s House differs from that at many other residential treatment communities in its modifications related to the presence of children. Specifically, rather than going off-site for specific parent training or parent-child services, such services and feedback around parenting are ever-present, beginning with the clients waking and getting ready for the day at 6:30 a.m., eating breakfast with their children at The Mother’s House, and then walking their children to the on-site daycare facility. While such tasks might seem rudimentary and routine in nature, the clients receive constant feedback about appropriate dressing, feeding, and transitions for children that they may otherwise not receive if they were receiving ancillary parenting services. For example, for many clients who parented while active in their substance use, the concept of following a consistent routine of waking with baby (vs. sleeping through the child’s cries due to being high or “strung out”), changing and dressing baby for the day (vs. leaving baby in his/her same diaper or clothing), eating breakfast with their baby (vs. propping a bottle or leaving baby alone with a bottle in the crib while using substances), and taking baby to a safe place for care (vs. leaving in front of the television or in a crib or with drug-abusing “friends”) are brand new behaviors that need to be practiced daily. The clients need constant support and feedback on why such exercises are critical to healthy parent-child relationships and child development. Following drop off at daycare, clients then return to the Mother’s House for intensive programming focused on major lifestyle change and abstinence from all substances of abuse, similar to the programming for non-parenting women. At approximately 4:00 p.m., the clients walk back to the daycare facility, where they reunite with their infants and satisfy requirements and responsibilities related to daycare (e.g., chores, completing logs related to baby needs). Again, this pick-up from daycare often involves on-the-spot feedback from staff around the
importance of being consistent and on time to reunite with baby, communication with the child’s daytime caregivers, and an attentiveness to the ways parents’ behaviors during separation and reunification with baby impacts development of secure attachments. From 5:30 p.m. to 8:30 p.m. the clients spend “bonding time” with their infants, a family-focused time with programming and structure developed by the infant mental health specialists. The purpose of this intentional time is to implement and further practice parenting skills focused on developmentally appropriate dinnertime, bath time, and bedtime routines; routines that have typically not existed for the mothers themselves or for their parenting of other children while active in their addiction. Something as simple as giving a bath, reading a story before bed, or singing a nursery rhyme emerge as foreign practices to these women, many of whom report parenting other children but acknowledge having little or no idea of how to spend “bonding” time with their baby. The presence of staff and the infant mental health specialists during this time fosters awareness about areas of concern and opportunities for intervention and practice with baby that may otherwise be missed if such services were off-site. This is especially critical from an infant mental health standpoint, as the interventions target a break in the cycle of substance abuse and maladaptive parent-child relationships that have often pervaded generations in these families. From 8:30 p.m. to 10:30 p.m., clients attend one final group focused on recovery from addiction, often with babies who are still awake or holding baby monitors during group to be able to appropriately attend to waking infants during this time.

Infant Mental Health Philosophy and Services

Cornerstones of The Harris-Haven collaboration include a model of nurturance and relationship-based care of the pregnant and parenting women of the Haven Mother’s House Program and an emphasis on fostering healthy parent-child relationships within the context of the recovery-focused addiction treatment environment. In addition to the day-to-day, often minute-to-minute
concrete examples of feedback and parent “retraining” that occur, there are specific services delivered by the infant mental health team to ensure that mothers and their infants receive balanced treatment with regard to addiction treatment and infant mental health. Each woman admitted to the Mother’s House program is assessed by a member of the Harris Infant Mental Health team and an individualized treatment plan for infant mental health services is determined during this intake based on client need. For those who are pregnant, an individualized infant mental health plan includes obtaining appropriate prenatal care, a birth plan centered around a supported and healthy delivery of baby (an opportunity/experience foreign to many of the women who might otherwise give birth to their infant as guarded prisoners shackled to a hospital bed), breastfeeding support, and immediate postpartum services including care focused on attachment and bonding with their newborn and screening and treatment for postpartum mood disorders.

Services include individual sessions, mandatory infant mental health groups, and developmental assessment with the Mullen Scales of Early Learning (Mullen, 1995) and several questionnaires measuring indicators of perinatal and parenting stress as part of standard Mother’s House programming. Groups provide a general foundation of knowledge and parenting support for these mothers, while also providing the Harris team with an opportunity to interface with each client and assess for additional needs around infant mental health. Mothers participate in infant mental health groups as part of their regular weekly MTC schedule. The infant mental health team that consists of a licensed psychologist, several post-doctoral fellows, and an addiction psychiatrist, facilitates these groups. Infant mental health groups include a process therapy group (i.e., New Additions) focused on addiction, mental health, and parenting needs, and an evidenced-based manualized parenting curriculum known as Partners in Parenting Education (Butterfield, 1996).
The process therapy group, termed “New Additions”, was developed by Dr. Harmon as a closed psychodynamically-oriented therapy group and is unlike any other group that runs in the treatment milieu. For example, unlike any other MTC group, New Additions insists on a temporary suspension of the hierarchy with regard to treatment phase status so that all members are on “equal ground.” There are strict rules prohibiting the kind of confrontation that is more typical of MTC milieu programming. The group leaders encourage the practices of respectful listening, supportive feedback, and the development of group cohesion. It is in this group that many of the women share intimate details and struggles of parenting in recovery, including issues related to ambivalence about long-term parenting, triggers for substance use-related to trauma (e.g. molestation, physical abuse, infant conceived by rape or prostitution), or grief and loss related to separation from other children as a consequence of addiction. For most of the women in treatment for addiction, this is the first place they begin to acknowledge the myriad of losses that accompany addiction, including loss of innocence/childhood, loss of loved ones, grief related to loss of relationships (especially with prior children), and time that they can never recover as a result of substance abuse. Intended as a safe holding environment, many women are sharing intimate details of their lives for the first time in the presence of peers and therapists who can bear witness to their experience and help them begin to heal.

The parent education group is based on the Partners in Parenting Education curriculum (How to Read Your Baby, n.d.) and is a manualized, strengths-based program to help mothers effectively read their infant’s cues, understand developmental milestones, and integrate age-appropriate expectations into their parenting approach. Facilitated by the infant mental health team, this curriculum has been tailored specifically to incorporate principles of recovery throughout the various units. For example, when learning about how to effectively determine an infant’s needs based on facial cues, body language, or cries, the group is asked to reflect on how their ability to read such cues while
parenting sober differs from behavior present while parenting as addicts. During the twice-weekly group meetings, the mothers learn content related to a particular topic on Monday afternoons, and practice specific activities related to the topic of the week in parent-infant groups the very next morning, in the presence of the same facilitator presenting the concepts. Certificates are awarded upon completion of each topic, with parents proudly congratulating each other for success in completion of the work. Though seemingly elementary and simple, this practice of “graduation” is particularly intentional and important from an infant mental health standpoint. Many of these women have never graduated or completed anything successfully prior to this group. The physical certificate and the proud congratulations and attention from staff and peers as they share their success is intended to serve as a model for infant mental health concepts of shared positive experience and mastery as their children simultaneously succeed in their own developmental trajectories.

Some mothers require additional infant mental health support beyond group treatment. Individual infant mental health sessions are then provided, with a focus on parent-infant psychotherapy as adjunct to standard milieu services and part of a client’s individualized treatment plan. Services are relationship-based and reflective in nature, with the notion that the relationship between therapist and mother will serve as a model for mother and baby. Parent-infant psychotherapy is routinely provided for those clients who are reunited with infants after some period of separation in order to help facilitate a smooth transition for both mother and infant as the infant moves into residence. Other circumstances that warrant individual services include severe mental health concerns (e.g., postpartum depression, bipolar disorder) impacting the parent-child relationship, substantial grief/loss issues as related to other children, safety concerns, ambivalence about parenting (e.g., considerations for adoption, outside placement), and relationship disturbances that surface around basic caregiving (e.g., sleeping, feeding, bathing) that usually require individualized attention. The orientation of parent-infant work is
grounded in attachment theory and principles of infant mental health, incorporating many of the well-established relationship-based infant mental health approaches including “Ghosts in the Nursery” (Fraiberg, Adelson, & Shapiro, 1980), “Wait, Watch, and Wonder” (Cohen, Muir, & Lojkasek, 2003), Infant-Parent Psychotherapy (Lieberman, Silverman, & Pawl, 2000), and Interaction Guidance (McDonough, 1993). Much like the model program described by Pajulo et al. (2006), the focus of parent-child intervention is on enhancing the relationship between caregiver and child, with an emphasis on relationship-based work as a critical and integrated part of the treatment milieu.

Case Example

(Names have been changed to protect confidentiality).

Marie is a 24-year old Caucasian female who was admitted to the Haven Mother’s House at 26 weeks pregnant. She was sentenced to addiction treatment by the criminal justice system on charges of drug possession and forgery, and in the event that she did not complete treatment, she would serve 12 years in prison. Marie has one other child, a two-year-old son Tyler. At the time of admission, Marie reported that her son lived with close friends and had been living with them since she was incarcerated three months prior as she did not have any family member who could care for her son due to their own involvement with addiction and the criminal justice system. She reported intermittent visits with him while incarcerated, having last seen him 6 weeks prior to admission, the longest time spent apart since his birth. When asked about her current pregnancy at intake, Marie reported that she was unsure of the identity of the father of her baby, and she was feeling “just okay” about having a child. She appeared motivated for addiction treatment, with a stated goal of “being back with my son and living a normal life”. She reported no history of mental health concerns or trauma to the intake team, and had no reported prior experience with addiction treatment. When asked about her history of substance use, Marie reported that she initially began using drugs and alcohol at the age of
16, with several reported periods of sobriety, the last of which came after finding out she was pregnant with her son at 16 weeks gestation until shortly before his first birthday when she reportedly relapsed as a result of “issues with his father”. She would not elaborate.

After several weeks of treatment in the milieu, staff began reporting that Marie was acting out, often disobeying rules of the milieu, sleeping during groups, and displaying either a negative or apathetic attitude. When confronted, she would reportedly become agitated and refuse to follow direction of staff and peers, then later present as tearful and afraid asking to call her son. In the weekly staff meeting, Marie became a central focus of staff concern, with staff reporting feelings of frustration, irritation with her attitude, and helplessness about how to best proceed with treatment. The Harris program was brought on board to meet with Marie and provide feedback and recommendations related to what might be “getting in the way of treatment”.

During her first session with the Harris team’s therapist, Marie was initially guarded and quiet, reporting that she was confused about why she was meeting with a psychologist, stating “I am not crazy”. Subsequent to the therapist’s lengthy explanation of infant mental health and the acknowledgment of a common goal in reuniting Marie with her son, Marie asked several questions related to confidentiality, disclosed a childhood history of foster placement due to abuse and neglect as a consequence of her own mother’s addiction, and seemed simultaneously hesitant and eager to talk with the therapist about her son Tyler, asking repeatedly if the therapist could help her to be able to see him during the next Kids Day Visit to the house on Sunday. Marie was given feedback that her attitude in the milieu was being perceived as defiant by peers and staff and shown how her own goals of reunification with her son were directly tied to treatment success and participation in the milieu. When asked to speak about her current pregnancy, Marie politely declined at that time, stating “my focus right now is on Tyler”.

Marie’s preoccupation with her seeing her son Tyler was brought back to the MTC treatment team and framed in the context of her own childhood history of separation from her primary caregivers as an overwhelming stressor interfering with her ability to focus on treatment. The team allowed Marie to contact her son’s caregivers and arrange for visitation on the following Kids Day, with agreement from Marie that she would demonstrate improvement in her interactions with peers and staff and requirement that she participate in group settings to begin to develop healthy connections to her peer sisters and staff.

Treatment staff reported a significant turnaround in Marie’s attitude in the milieu after seeing her son Tyler and setting up regular visits as part of her treatment plan. Marie returned for a follow up session with her infant mental health therapist two weeks later and reported feeling reassured that “this place is not like others where they watch you to find a way to keep you away from your kids”. She again declined to speak in her individual session about her current pregnancy, stating only “it will be fine”, but did agree to participate in New Additions group to share something about herself that week, with a commitment from the therapist that her participation would not go unnoticed and would be shared with the larger treatment team as evidence of her investment in recovery from addiction and parenting goals.

That week in New Additions group Marie was reported to be highly distracted, appearing distressed with her hands on her pregnant belly (now 31 weeks) for the majority of group. When facilitators questioned her, she became irritable and defensive in group. When the group was asked to support Marie, an upper phase peer commented on Marie’s lack of engagement with her pregnancy and the perception among others that she only cared about Tyler and did not want this baby as she never talked about the baby or acknowledged fetal movement in the way that the other women would,
often looking “mad when her baby moves inside of her”. Marie became extremely tearful and, with a great deal of prompting and support, began to share her story.

It was in New Additions that Marie first disclosed her experience of a violent rape that led to her current pregnancy and subsequently described the way in which fetal movement reminded her of the attack, becoming increasingly stressful as the baby became more active nearing term. Marie also shared that she did not think she wanted to parent the baby given the circumstances but was fearful of being returned to prison if she gave up this baby and consequently being separated from her son Tyler for years. Marie’s peers in the group began to share their own histories of trauma, and one particular peer disclosed that her own daughter, now 4 months old and living in residence, was in fact the product of a sexual assault as well, something she had not yet disclosed in the milieu.

Marie’s disclosure led to an extensive discussion among peers in the group about specific ways they could help Marie cope with the distress of triggers (both internal and external) related to her trauma, with a majority of strategies focused on utilizing learned coping skills in the context of supportive peer relationships. Similarly, the Harris team’s therapist engaged in extensive consultation with the Haven Mother’s House treatment team to determine the best course of treatment for Marie to effectively integrate necessary addiction treatment interventions with mental health and infant mental health needs. Marie’s plan came to include specific milieu modifications to address PTSD symptoms, a clearly outlined plan for support during labor and delivery, counseling around options for adoption and consistent reassurance that she would in fact not be returned to prison (and separated from Tyler) if she chose not to parent her baby, and weekly sessions with a Harris team member for integrated infant mental health care.

Over the course of the next several weeks, Marie began to share more about herself with her counselors and peers in the treatment milieu. Behavioral interventions were designed with specific
attention to trauma, and clear limits were set with the treatment staff and clients about nonjudgmental and neutral responses to Marie’s ambivalence about her pregnancy. While the treatment milieu worked to address Marie’s behavior of low frustration tolerance and poor coping, there was careful consideration to be sure Marie’s visits with Tyler remained consistent, as missed visits would predictably activate setbacks in Marie’s treatment, triggering an immediate return to the agitated or apathetic Marie staff first encountered. When offered support for her delivery at the hospital, Marie’s choice of two particular peer sisters to be present at the birth of her baby (instead of requesting family who were likely still using substances) served as a clear indicator to staff that Marie was connected to her treatment “family” in a healthy way and was feeling safe. Her relationship with her Harris infant mental health therapist remained a consistent and powerful source of support, and as Marie began to disclose a long history of childhood abuse, domestic violence, and previous perinatal losses (none of which was mentioned at intake), it became clear that there were many “ghosts” permeating Marie’s view of the world and herself as a woman and mother. With her trust and permission to share relevant pieces of her therapy, her disclosures to her Harris therapist provided an avenue for active dialogue among the multidisciplinary staff and individualized interventions tailored to Marie’s needs as a recovering addict and mother.

The birth of Marie’s daughter Hope was a significant turning point in her addiction treatment. For example, though initially still ambivalent about whether to parent her new baby or give her up for adoption, caring for Hope as a healthy, drug-free, newborn while clean and sober herself served as a powerful catalyst for transformation and change. Marie began to realize and acknowledge the severity of her addiction, uncover the guilt and remorse driving her current relationship with Tyler related to parenting him while active in her addiction, and work on her unresolved grief associated with previous pregnancy losses that had never been acknowledged. Attending parenting groups and
practicing newly learned skills in the presence of peers and staff sparked a new confidence in her mothering abilities, and viewing videotaped interactions of herself with her baby daughter in parent-child therapy generated insights related to her capacity to break a cycle of intergenerational addiction and criminality present in her family for as long as she could remember. Further, having a daughter inspired a newfound awareness of her history of victimization and maladaptive relationship patterns with men. Determined to break the cycle of abuse so that her daughter would not endure the same suffering she did, Marie confronted extremely difficult issues related to her role in maladaptive relationships as a central focus of recovery from her addiction and relapse prevention.

The devoted collaboration and partnership between the infant mental health team and the addiction treatment team in the perinatal period led to a comprehensive understanding of treatment need and individualized care for Marie. As the MTC targeted behavioral and psychological change around her addiction, the Harris team targeted the barriers to success related to infant mental health. Marie’s story is not unlike the majority of the women at The Haven Mother’s House, where an inextricable link between addiction and infant mental health highlights the necessity of integrated care, as successful treatment of one facet could not endure without equal attention to the other.

Clinical Implications

In an independent review of program outcomes for community corrections across the state of Colorado, the Haven MTC was among top programs with regard to recidivism success rates, despite higher relative criminal history scores for treated offenders (criminal history score serves as an indicator of risk). In fact, approximately 90% of women who complete treatment at the Haven programs remain drug-, alcohol-, and crime-free two years after program completion (Hetz-Burrell & English, 2006). Such impressive success relative to other treatment programs was linked to the TC modality of substance abuse treatment and the presence of specialized female-only programming,
highlighting the importance considering residential treatment with specialized, gender-responsive service delivery as best practice for this population. With regard to mothers living in residence with infants, over 130 babies have been part of the Haven Mother’s House program to date, with 100% of babies born to mothers admitted during pregnancy born drug-free, consistent with the mission of the program. Despite being drug-exposed at some point during pregnancy prior to program admission, the overwhelming majority of these infants appear to be reaching six-month developmental milestones on time, with little need for early intervention service.

There is strong clinical support for treating mothers and babies together in residential treatment for substance abusing women. However, a robust body of empirical evidence for the efficacy of such programs in terms of abstinence rates, infant outcomes, and parenting capacity is just now emerging. Future research must consider examining the Haven and Haven Mother’s House programs as discrete entities to determine if recidivism rates are even more striking when women and babies are treated together in residential care for substance abuse among this high-risk population. Further, evaluation of integrated infant mental health into this type of addiction treatment as a superior model needs to address outcomes related to specific pregnancy and birth outcomes, developmental trajectories of these infants, relational assessments of mothers and infants in residence, and long-term follow up to determine if the protective factors associated with family-centered parental treatment of substance abuse are sustained over time. Such studies are currently underway.

Among all populations struggling with addiction, pregnant and parenting women are especially complicated, as treatment must consider their role as primary caregivers to their children and the enormity of that role in influencing treatment outcome and societal cost. Existing cost-benefit analyses examining the benefits of family-centered treatment for substance abuse and services for pregnant women reveal savings in a number of areas, including child welfare, crime, foster care, and improved
birth outcomes, with recidivism cost savings associated with specific crimes like child abuse at $60,000, and projections of costs associated with meeting the needs of drug-exposed infants over a lifetime exceeding $1 million dollars per child (Miller, Cohen, & Wiersema, 1996; Kalotra, 2002; Werner et al., 2007).

With existing research pointing to improved retention and improved outcomes for family-centered treatment, and the numbers of infants born drug-free and thriving in our program alone, the case for a best-practice model of integrating infant mental health practice into residential substance abuse treatment for families seems obvious. However, as others have noted (Heffron, Purcell, & Schalit, 2007), the task of integrating infant mental health service into residential drug treatment is not without challenges and requires unrelenting collaboration and coordination of care. The partnership between the Haven MTC and the Harris Program in Child Development and Infant Mental Health has provided an exemplary opportunity to imbed comprehensive infant mental health services within the addiction treatment environment. Appropriate modifications have been made to both the MTC model of addiction treatment and to infant mental health treatment protocols to allow them to effectively serve the intense and acute needs of addicted mothers and their infants. As a result, mothers learn how to lead lives free from substance abuse while actively practicing the demands of parenting. The success of this program relies on the immense commitment of both treating agents (the Haven and Harris Programs) to maintain the core principals of both recovery and infant mental health, and the ensuing benefit to our infants, mothers, their communities, and society as a whole are unmistakable.
Reference List


Retrieved March 20, 2008, from How To Read Your Baby Web site:

http://www.howtoreadyourbaby.com/PipeCurriculumandModel.html


Kalotra, C. J. (2002). *Estimated costs related to the birth of a drug and/or alcohol exposed baby.*

Retrieved from Office of Justice Programs Drug Court Clearinghouse and Technical Assistance Project at American University Web site:


Relapse Prevention: Practical Resources for the Mental Health Professional (pp. 141-167).
San Diego: Elsevier Press.


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