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A STUDY OF SUBSTANCE ABUSE RECOVERY PROGRAMS:

PERCEPTIONS OF MOTHERS IN RECOVERY

A project based upon an independent investigation, submitted in partial fulfillment of the requirement for the degree of Bachelor of Arts in Social Work.

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Abstract

There is a strong correlation between parental substance abuse and child maltreatment, and many substance abusing parents do not or are not able to access treatment recovery programs. The literature indicates that 8.3 million children are living with a substance abusing parent in the United States, and of these parents 2.4 million do not receive substance abuse treatment and recovery programs (Carlson, 2006, p.97). As a result, many of these children are removed from their homes due to child maltreatment. This research study examined what mothers in recovery (with children in state custody) in a Northern Rhode Island social service agency have experienced as barriers when accessing substance abuse treatment programs. It was hypothesized that mothers will more effectively engage in substance abuse recovery when they are enrolled in a comprehensive program that encompasses their goals of reunification as well, which in turn will make recovery more attainable. This study surveyed eleven women enrolled in this community agency to inquire about their insights into obstacles they have encountered, past and present, when accessing substance abuse treatment as well as what would be helpful for their recovery and reunification. Results showed that some common obstacles when accessing treatment were transportation, fear of child welfare involvement, cost of programs, and wait lists. The responses collected confirmed that these mothers are interested and proactive about bringing their recovery and parenting efforts together in order to reunify their families as soon and successfully as possible. Implications for practice, policy and research were discussed.

Introduction

Although one of the objectives of the child welfare system is protect children from maltreatment and abuse, there is a great need for services for the substance abusing parents themselves. "A 1997 Child Welfare League of America (CWLA) study of state child welfare agencies estimated that 67% of parents in the child welfare system required substance abuse treatment services, but child welfare agencies were able to provide treatment for only 31% of the families who needed it" (Banks & Boehm, 2001, p. 1). Substance abusing parents make up the majority of child abuse and neglect cases, so it is essential to target the root of the problem- the substance abusing parents- rather than merely rescuing the children and later placing them back into a potentially dangerous environment.

Although the majority of child welfare cases involve substance abuse by the parents of the child, there is relatively limited literature and research on this aspect of child welfare. "The issues of substance abuse and its effects on the individual, family, and community remain a major challenge to the social work profession" (Gruber, Fleetwood, & Herring, 2001, p. 267). Unfortunately, many times child welfare workers do not have sufficient training and knowledge about substance abuse, which can greatly inhibit the effectiveness of services, recovery, and reunification (Tracy, 1994, p. 537). It is essential to understand the root of child maltreatment, in order to solve the problem and stop the cycle of relapse. The other injured party in the substance abuse dynamic is obviously the children. "Several reports have documented that once children from substance abusing families enter placement, they tend to remain in care and are less frequently reunified with their biological parents or free for adoption compared with

children placed for reasons unrelated to substance abuse" (Tracy, 1994, p. 535). As a result of the stress on a child, the Adoption and Safe Families Act, introduced in 1997, states that, "substance-abusing parents have as little as one year in which to comply with reunification requirements, including attaining and demonstrating recovery from their addiction, or face permanent termination of their parental rights" (Rockhill, Green, & Newton-Curtis, 2008, p. 64). Additionally, Rockhill et al. (2008) states, "many in both the child welfare and substance abuse treatment services have been concerned that a 12 to 15 month time frame is inadequate for parents to successfully enter and complete court-ordered treatment, given the obstacles to treatment" (p. 64). There are several barriers and obstacles that substance abusing mothers seeking treatment have to overcome. Rockhill et al. (2008) mentions some obstacles which include waiting lists, lack of support systems, cultural incompetency, and inability to pay for treatment services and programs (p. 67). Therefore there is a great need to provide the most effective and efficient treatment possible to these mothers, which first requires asking them what they need from a successful recovery in order to be reunified with their children.

This study's goal is to understand the needs of substance abusing mothers in the child welfare system that need treatment recovery in order to reunite with their children. This study will focus on substance-abusing parents whose children are in an out-of-home placement, due to child maltreatment. Substance abuse will not have to be the primary cause of the out-of-home placement, but will have been a factor. The literature addressing treatment and recovery programs of substance abusing mothers/parents in the child welfare system will be examined. Additionally, first-hand experiences and expectations of recovery and reunification will be collected from women enrolled in a Northern Rhode

Island social service agency that focuses on recovery and visitation between children and parent, in order to identify the objectives of a successful recovery program. The center hopes to provide the most effective substance abuse recovery programs possible in order to reunite and stabilize these families. It will provide recovery coaching for the substance abusing mothers, assistance to the foster family that their children have been placed in, as well as conducting visitation with the biological parent at the agency. This holistic approach aims to bring the mother's issues and goals together, in order to achieve a better recovery, reunification, and prevention of relapse. Information gathered from this center will provide necessary current, relevant, and first-hand information from those who are utilizing and receiving services, to be used in this study to report and educate others in the field.

This study will explore the obstacles, barriers, and gaps in the existing recovery process for substance-abusing mothers. It will identify the needs of the mothers in the short and long term, and outline objectives for a successful, sustainable program for substance-abusing mothers. It is essential to develop an optimal plan of action for this category of women because children depend on their mother's well being for their own safety and well being.

Literature Review: Main Points

There are various causes of substance abuse, which can lead to addiction and can result in severe consequences for mothers, such as involvement of the child welfare system. Child maltreatment would hopefully lead to recovery treatment, which can be very difficult for mothers and requires many support structures. Recovery treatment is, however, the only way for mothers to be reunited with their children and to move on with

their lives. The U.S. Department of Health and Human Services reported that 8.3 million children live with a substance abusing parent, of which 3.8 million involve alcohol and 2.1 million involve drugs. (U.S. DHHS, 1999, as cited in Carlson, p. 97). Despite this, most of these 2.4 million parents do not receive treatment for recovery (Carlson, 2006, p.97). It is well known that there are not enough substance abuse treatment programs for women (Marsh, D'Aunno, & Smith, 2000, p.1237). According to Gruber, Fleetwood, & Herring, (2001) "the goal of the recovery process is to have the recovering individual assume increasing levels of responsibility for dealing with problems and issues of a chemically free lifestyle" (p. 270). Responsibilities and pressures of recovery as well as dealing with the child welfare system can be very difficult for substance abusing parents.

A parent in treatment recovery with children in an out-of-home placement has become a more common occurrence in recent decades. One reason for this sharp increase is the crack epidemic in the late 1980s and 1990s, of which most of the cocaine- and crack-addicted parents were mothers (Carlson, 2006, p. 98). Additionally, "the interrelationship between substance abuse and child maltreatment is complex and is linked with other social problems including poverty, mental illness, family violence, and inadequate housing" (Carlson, 2006, p. 98) Therefore, there are many different causes and influences that lead these parents to addiction.

Causes of Addiction

"Drug addiction, also known as substance dependence, is a chronic, relapsing disorder that is characterized by 1) compulsion to seek and take the drug, 2) loss of control in limiting intake, and 3) emergence of a negative emotional state (e.g., dysphoria, anxiety, irritability) when access to the drug is prevented (Koob & Moal,

1997, as cited in Galanter & Kleber, 2008, p. 3). "In addiction, drug-taking behavior progresses from impulsivity to compulsivity in a three-stage cycle: binge/intoxication, withdrawal/negative-affect, and preoccupation/anticipation." (Galanter & Kleber, 2008, p. 3). Impulsivity consists of the tension or arousal before taking the substances, followed by pleasure and gratification while taking the substances, and lastly regret and guilt afterwards (Galanter & Kleber, 2008, p. 3). On the other hand, those with compulsive substance abuse disorders feel anxious before taking substances as a repetitive behavior, which is followed by relief when acting upon this compulsive behavior (Galanter & Kleber, 2008, p. 3). Animal research has given a great deal of evidence behind the neurobiology of addiction in regard to the three stage cycle of addiction. During the binge/intoxication stage there is an, “activation of specific neurochemical mechanisms in specific brain reward neurochemical systems in the basal forebrain (dopamine, opioid peptides, GABA, serotonin, and endocannabinoids)” (Galanter & Kleber, 2008, p. 12). Dopamine is an acute reinforcing agent in the neurobiology of addiction, along with opioid peptides, GABA, serotonin, and endocannabinoids (Galanter & Kleber, 2008, p. 5). The release of dopamine tells the brain reward system to ‘do it again’, and generates lasting memories that link the particular drug to pleasure (“Drug addiction and the brain: effects of dopamine on addiction, 2007). In the second stage, withdrawal/negative-affect, there is a lack of regulation of the reinforcing agents such as dopamine and serotonin in the brain reward neurochemical systems in the basal forebrain (Galanter & Kleber, 2008, p. 13). Lastly, during the preoccupation/anticipation stage, the anti-reward systems are disrupted and produce a stress-induced state, which suggest the vulnerability for a dependence on substances as well as relapse (Galanter & Kleber, 2008, p. 13). Therefore,

this cycle of disrupted and unregulated neuro-activity reinforces the want and need to continue this cycle of addiction.

Addiction is still seen, especially in public policy, as a weakness and a crime (Brust, 1999, p. 1531), when in fact there is vast evidence that one can have a genetic predisposition to substance abuse. Thus, the unbiased nature of addition causes the various types of substance abuse to be found “across geography, race, ethnicity, and socioeconomic status and adversely affect the individual and those around him or her, as well as society at large" (Galanter & Kleber, 2008, p. 18). Women have a stronger family history correlation of alcoholism than men (Haver, 1987, as cited in Lex, 1994, p. 291). However, the genetic factors involved in family alcohol histories are portrayed differently in women (Lex, 1994, p. 291). Women’s addictions are more likely than men’s to be influenced by environmental conditions, such as exposure to alcohol and social status (Lex, 1994, p. 291). Hence, addiction cannot solely occur due to genetics, but exposure to the substances is necessary as well (Galanter & Kleber, 2008, p. 17). However, it is important to understand the initial genetic influences as there are different levels of risk for someone with a genetic predisposition to addiction (Galanter & Kleber, 2008, p. 17). As a result, if one is able to better understand the biology behind the addiction and then one can explore the environmental issues that have influenced the substance abuse. (Galanter & Kleber, 2008, p. 17).

Consequences of Addiction

There are severe consequences that stem from addiction. First, a person using illegal drugs can also become involved in other criminal activities such as dealing drugs, prostitution, or stealing (Singer, 1995, as cited in, Carlson, 2006, p.100). In addition to

the effects of substance abuse on the user, there are various effects on their children which include alcohol and drug use of their own, lower self-esteem, lower educational performance, amongst others (Doris, Doris, & Wright, 1995, as cited in Gruber et al., p. 268). Another extremely serious consequence of substance abuse is that is it often a gateway for child maltreatment which leads to the children being removed and placed in an out-of-home placement (Carlson, 2006, p. 101). Child maltreatment includes neglect, physical abuse, sexual abuse, or emotional abuse ("Defining child abuse and neglect", 2009). However, this sudden wake-up call of being involved with Child Protective Services can sometimes cause a parent to seek treatment (Rockhill, Green, Newton-Curtis, 2008, p. 74).

It is clear that substance abusing parents are often not able to play a successful parenting role (Gruber et al., 2001, p. 267). "In some cases the parent never had a firm foundation for parenting, whereas in other cases there was a foundation or period of adequate parenting that was interrupted by drug abuse" (Carlson, 2006, p. 101). Despite this inadequacy in care, a study found that most of the participating mothers wanted to be good parents (McMahon & Luthar, 1998, as cited in Carlson, 2006, p. 102). When it comes to maltreatment, "neglect is thought to be a more serious problem than abuse. Specific effects include abandonment, inconsistency, harsh and erratic discipline, and low frustration tolerance" (Davis, 1990; Harden, 1998; U.S. DHHS, 1999, as cited in Carlson, 2006, p. 101). According to the Rhode Island Kids Count, neglect comprises the largest portion of child maltreatment at 78% of maltreatment cases in Rhode Island ("Child abuse and neglect: KIDS COUNT Factsheet", 2008). Parenting can therefore be gravely affected by substance abuse, resulting in the intervention of the child welfare system.

Women and Addiction

With regards to women there has been some insight into treatment with women's issues in mind. "Beginning in the 1980s, addiction specialists began to realize that there were important gender-specific differences, with important implications for treatment. For example, patterns of addiction differ, with women often abusing different substances (e.g., prescription drugs) and using alone." (Carlson, 2006, pg.98). In addition, in comparison to men, women's substance abuse is more commonly a reaction to a stressful life event, abuse by a partner, or they use with a romantic partner (Nelson-Zlupko, Kauffman, & Dore, 1995, as cited in Carlson, 2006, p. 99). And if a substance abuse problem does develop, women have reported addictions of greater severity and addiction occurs faster than men as well as experiencing more health related consequences (Bradley et al., 1995, as cited in Green, 2006, p. 56). Another significant difference between men and women is that women are less likely to receive support during treatment from their partners than men are while treatment (Kane-Cavaiola & Rullo-Cooney, 1991, as cited in Rockhill et al., 2008, p. 80). However, it is also essential "to recognize that it is unwise to work with a female chemically dependent client all alone, and merely advise her to discontinue relationships with former drug dealing and violent partners and spouses who are still the father of one or more of their children" (Wallace, 1994, p.92). These relationships may not be supportive or positive influences, however, "one cannot merely recommend and facilitate the dissolution of the family – especially African American, Latino, and other poor and already besieged minority family structures" (Wallace, 1994, p. 92). Misinterpreting the value of human connection for women in treatment will ultimately result in women dropping out of treatment (Wallace,

1994, p. 92). Understanding differences between substance abusing men and women is important because it can greatly affect the effectiveness of a treatment program.

Barriers to Treatment Programs

It is important to examine the barriers that women face in seeking treatment before analyzing treatment programs, as these obstacles impede the entranceway and enrollment for women seeking recovery. First, denial of their addiction is an important barrier for some substance abusing parents (Ebener & Kilmer, 2003; Thom, 1986, as cited in Rockhill et al., 2008, p.73). Secondly, even if a mother is accepting of her problem, she more likely to be stigmatized and feel shame and guilt about her addiction than a male. This double standard may prevent her from seeking treatment (Beckman, 1994; Janikowski & Glover, 1994; Magura & Laudet, 1999; Nelson-Zlupko et al., 1995; Reid, 1996, as cited in Carlson, 2006, p. 103). Once a woman decides to reach out to a treatment program, there are often long waiting lists, which allow someone time to change their mind about recovery (Ebener & Kilmer, 2003, as cited in Rockhill et al., 2008, p. 65). Fourth, in a recent study of assessing substance abuse treatment programs, Rockhill et al. (2008) found that poverty was the biggest barrier to receiving treatment (p. 76). In most states publicly funded health insurance will fund outpatient treatment programs, but the common delays, eligibility paperwork, and application process is yet another barrier (Rockhill et al., 2008, p. 76). In conjunction with payment difficulties, some parents in recovery are unable to complete a treatment program because their insurance no longer covers their provider (Rockhill et al., 2008, p. 77). Additionally, poverty was a barrier to treatment when “parents felt discouraged due to concerns about being able to both remain employed and participate in treatment, or fear of losing

subsidized housing should they enter residential treatment" (Rockhill et. al., 2008, p. 77). Another barrier is that treatment programs may not be available or known well to minority communities, thus hindering minorities' abilities to access to recovery programs (Kail & Elberth, 2002; Kine, 1996, as cited in Rickhill et al., 2008, p. 66). Finally, the child welfare system may be asking too much of the parents at once. Often the system is expecting parents to complete treatment, have appropriate housing, and sufficient income in order for their children to be returned to them. In Rockhill et al.'s (2008) study a parent expressed their frustration:

> They want me to participate and complete a parenting program …, then they want me to participate in a domestic violence program . . . And they also want me to complete a drug and alcohol evaluation and complete treatment . . . then they want me to maintain stable employment. (p. 78)

Thus, there are numerous barriers and obstacles for seeking and accessing treatment programs. This testament provides insight into the issues of how involvement with substance abuse treatment and recovery as well as the child welfare system can be difficult even if a woman is able to access these services.

Analyzing Treatment Programs

Because there are various factors that contribute to substance abuse, there are also various issues to be addressed and different services to be provided. There are different types of treatment programs, and best practice models include comprehensive services, intensive programs, services beyond recovery such as parenting skills, and often times most importantly, models that recognize the centrality of these women's roles as mothers (Carlson, 2006, p.106). Recognizing the family role of recovering mothers, it was found essential to provide additional services such as parenting skills classes, family therapy, and child care (Wellisch, Perrochet, & Anglin, 1997, as cited in Carlson, 2006, p. 105).

“Simply becoming drug- and alcohol-free will not in and of itself improve parenting for many of these parents, especially in light of the poor parenting received by many addicted women when they were children (Mejta & Lavin, 1996, as cited in Carlson, 2006, p. 105). This encompasses the holistic approach that these women are not only recovering addicts, but also mothers, and they are also most likely overcoming some type of trauma or disorder themselves.

It is important to identify and understand the causes of substance abuse for women in order for these women to make a successful recovery (Carlson, 2006, p. 99). As discussed previously, common risk factors for chemical dependency are mental disorders such as post traumatic stress disorder, anxiety, and depression (Reid, 1996, as cited in Carlson, 2006, p. 104). Additionally, past trauma histories should also be addressed in order to avoid the risk of intergenerational effects on the mother’s children (Carlson, 2006, p. 105). “Programs must include staff with advanced clinical credentials and training to adequately address the complex problems chemically dependent women present; both individual and group therapy should be available” (Schliebner, 1994, as cited in Carlson, 2006, p. 105). Qualified care and support of others is frequently mentioned as a necessity to a successful treatment program. An out-patient rehabilitation center in New York City found that in a client satisfaction survey, “the most helpful aspects of the program were peer support from other clients, concerned staff, assistance with parenting, and individual counseling, which many wanted more of (Magura, Laudet, Kang & Whitney,1999, as cited in Carlson, 2006, p. 109). Women also are more likely to benefit from programs with a self-help approach, such as Alcoholics Anonymous (Timko et al., 2002, as cited in Green, 2004, p. 59). Clearly, comprehensive services ranging from

outreach, relapse prevention, and aftercare programs with competent program leaders, will allow for the best recovery in all aspects of these mothers lives (Carlson, 2006, p. 106).

Treatment Programs: Home-based

There have been some successful recovery programs that provide home-based services. “Family-centered home-based approach would help women carry out their roles as parents and focus on the needs of their children and at the same time receive support and intervention services” (Gruber et al., 2001, p. 270). A home-based care program in Rhode Island, called Project Connect, provides at home substance abuse assessment and counseling as well as a range of other family services; an assessment has shown that the majority of the caseloads in project Connect made progress on their goals within the program (Gruber et al., 2001, p. 276). A second home-based treatment program is the Bridges Program, which hopes to "bridge" the transition a substance abusing parent has to make when transitioning from a recovery program to being a parent, adult, and provider (Gruber et al., 2001, p. 276). "As a pilot program, Bridges is striving to develop the essential community links that will tie child and family services to the substance abuse recovery network" (Gruber et al., 2001, p. 276). This program believes that home-based work could be more effective because it breaks through the walls of the program and into the client's home to reinforce the role of being a provider to their children (Gruber et al., 2001, p. 276). Home-based programs provide a different strategy for treatment programs to examine because the home-based approach may provide a more comprehensive recovery and treatment plan.

Treatment Programs: Cultural Competency

Cultural influences and values are vital aspects to explore when working with cross-cultural clients. There are different ways that various cultures cope with recovery, so in order for a successful recovery, these aspects need to be explored. For example, spirituality is often a very large part of African American upbringing and support system, so it is important to tap into and inquire about spirituality in treatment with African American women (Lewis, 2004, p. 469).

Another coping mechanism of African American women is that they often need their own space to process and negotiate relationships with themselves as well as with their children, therefore, even if not required, these women may choose to house their children with a family member throughout recovery (Lewis, 2004, p. 468).

Treatment Programs: Staff

The staff in a treatment program is extremely important for the success of the recovery program. Firstly, the program should attempt to have a diverse staff in order to provide the clients with a more comfortable environment so that productive work can be done. In a study of African American women in a treatment program they identified the need for more African American women on the staff of the recovery program (Lewis, 2004, p. 468). “Even though they were able to successfully recover, the women emphasized the extreme difficulty in doing so with limited access to African American counselors” (Lewis, 2004, p. 468). Additionally, “exposure to role models who have successfully negotiated difficult challenges in their lives and communities is a culturally appropriate treatment tool for African American women in recovery” (Lewis, 2004, p. 469).

Gender is also an important aspect to consider when choosing staff for a treatment program. Females can feel alienated in a program that is predominantly run by male staff (Carlson, 2006 p. 103). “In the early stages of recovery in particular, women have more difficulty trusting male program staff, especially in light of their extensive victimization histories (Nelson-Zlupko, Kauffman, & Dore, 1995, as cited in Carlson, 2006, p. 103). It is essential to have female staff in treatment programs involving women, in order to provide a comfortable environment where disclosure, especially of gender-related issues, is promoted and accepted; women staff members also provide a role model for the women in treatment (Luthar & Walsh, 1995, as cited in Carlson, 2006, p. 103). Adequate training of staff members is also essential because child welfare workers often to not have sufficient training and knowledge about substance abuse and recovery (Tracy, 1994, p. 537). Along with sufficient training, the staff needs to ensure that caseloads are not too high. “High case loads in many child welfare agencies hamper efforts to individualize services, conduct adequate assessments, and deal promptly with crises” (Tracy, 1994, p. 538). Therefore, while staff demographics may seem like a small detail in treatment programs, however they can drastically affect recovery process and efficiency.

Relapse

On the other side of recovery, it is important to remember that substance abuse recovery is a long process that often includes periods of relapse (Carlson, 2006, p. 98). “Approximately one-third of those who received substance abuse treatment become abstinent on the first attempt, one-third relapse but eventually become abstinent, and one-third become chronic relapsers” (U.S. DHHS, 1999, as cited in Carlson, 2006, p. 98)

> "The black and white dynamics of abstinence and relapse, which traditionally have meant treatment failure and possible rejection from treatment for the client,

> are replaced with a model that accepts the client where he or she is in the change process, reducing barriers and stigmas in treatment for clients who are yet unable or unwilling achieve abstinence" (Marlatt, 1996, as cited in Barrett & Marlatt, 1999, p.176).

It is vital to remember that relapse is often a part of recovery and a treatment program must provide ways to cope and deal with momentary relapse. For example, families play a crucial role in the recovery process of an addict (Gruber et al., 2001, p. 268). “Studies show that individuals are more likely to relapse when families fail to maintain involvement in treatment activities (educational, counseling, and self-help programs) than individuals from families who do stay involved” (as cited in, Gruber et al., 2001, p. 268). Additionally, when families are involved in the recovery process they can be a support system as well as being able to identify relapse warning signs (Daley & Raskin, 1992, as cited in Gruber et al., 2001, p. 268).

Reunification Risks for Children

Another component of this problem is the children that have been removed from their substance abusing parents. In addition to the mother in recovery, the child needs attention with regards to helping the child cope and understand the different aspects of substance abuse (Julianna & Goodman, 1992, as cited in Gruber et al., 2001, p. 271). There are also numerous stresses that children face when they return home. Some of these include:

- Chaotic and often dangerous neighborhoods
- Poverty and homelessness or unstable housing
- A parent whose addiction is likely to take a precedence over the child’s basic needs
- A parent who lacks an extended family and community support system

- A parent who may have been victimized herself as a child or adult
- A parent with poor parenting skills and few or no roles models for effective coping (Feig, 1990; Gittler & McPherson, 1990, as cited in Tracy , 1994, p. 535)

Thus, in the development of a program it is essential to try and break down these multiple stresses and ensure that there are trainings and supports for both the mother and children after reunification.

In conclusion, child maltreatment is often a result of substance abuse, which involves the state child welfare system working to reunify the substance abusing parent with their child or children. Treatment and recovery is essential in order for this to happen. It is essential to understand that women bring different issues to treatment than men do (Marsh et al., 2000, p. 1238). In order to provide the most effective services and treatment for these parents, a treatment program needs to research and acknowledge the challenges and obstacles for these parents. It is also evident based on the literature that continuing assistance and support needs to be provided after treatment, especially when children are being returned home to their recovering parents. Examining these needs for short and long term treatment will help to outline objectives for a successful recovery program.

Literature Review: Opposing Points

It is evident that there are several specific needs for women in substance abuse treatment, and even more specific needs for mothers with children in state care. There are several approaches and perspectives to substance abuse treatment programs. Some use different methods according to research, treatment populations or agency mission statements. It is essential to examine all available approaches in order to design and

provide the best possible treatment program for this particular population within the substance abuse community.

Similarities of Men and Women

There is extensive evidence regarding the differences between men and women concerning substance abuse treatment programs, however there are also significant similarities between the two genders. “Recent research shows that women’s and men’s substances use patterns have become more similar in the past few years” (McPherson et al., 2004, as cited in Green, 2006, p. 56). Furthermore, men are just as likely as women to engage and complete treatment (Brady & Ashley, 2005, as cited in Green, 2006, p. 58), and women do just as well in the outcome of treatment as men (Green, 2006, p. 58). Men are often stigmatized as having an unlawful past, however in a study of men and women enrolled in a treatment program, an equal number of each gender had experienced previous problems with the law (Lex, 1994, p. 311). Additionally, support systems for both men and women are extremely important in treatment recovery, and often *both* sexes do not receive much support outside their immediate friends and family (Lex, 1994, p. 310). Research has shown that women may be less likely to receive support from their partners (Nelson-Zlupko, Kauffman, & Dore, 1995, as cited in Carlson, 2006, p. 99), however men may appreciate these supports more, as a study found that men perceived encouragement from others as positive (Lex, 1994, p. 311). A woman’s involvement with the child welfare system can encourage treatment, as they want to be good parents to their children (Rockhill, Green, Newton-Curtis, 2008, p. 74), and similarly a study showed that some of the major reasons that men enter treatment include the fear of losing children as well as concerns about health, possible marital breakup, or fear of job loss (Lex, 1994, p.

311). Thus, there are several similarities between men and women in the various aspects of addiction, so these issues are not only applicable to women because they have children, but these issues apply to men as well.

Specific Needs of Men

There have been several points mentioned regarding the specific needs of women in treatment recovery programs, however men similarly have their own specific needs in treatment. There are various stigmas placed on someone in addiction recovery, and one stigma or assumption men have indicated is the concern that peers might discover they are attending a substance abuse treatment program and assume that these men are lacking in masculinity (Lex, 1994, p. 310). There is also a fear amongst men that they might be labeled as requiring psychiatric care (Lex, 1994, p. 310). Therefore, it is necessary to explore some of the specific issues men face when seeking, engaging in, and completing treatment recovery.

Treatment Outcome

There is sufficient evidence that women have specific needs in treatment, thus requiring women only treatment programs. However, while gender-specific treatments may be beneficial for some women, “one recent study randomly assigned female participants to women-only versus mixed-gender programs and found no difference in outcomes” (Kaskutas et al.,2005, as cited in Green, 2006, p. 60). In fact some research suggests that in mixed-gender groups, men tend to be more expressive of their emotional issues and then receive nurturing support from the women in the group (Lex, 1994, p. 318). “Despite concerns that women would fare worse than men, current evidence

suggests that, overall, women's substance abuse treatment outcomes are as good as, or better than, men's treatment outcomes" (Green, 2006, p. 59).

Even though treatment outcomes are similar between men and women, women have been found to have better long-term recovery outcomes (Dawson et al., 2005; Weisner et al., 2003, as cited in Green, 2006, p. 60). Completion of treatment recovery programs is extremely important as the long-term statistics indicate from a recent study found that "women were nine times more likely to be abstinent than women who did not complete, whereas men who completed treatment were only three times more likely to be abstinent than men who did not complete treatment" (Green et al., 2004, as cited in Green, 2006, p. 60). Due to similar immediate treatment outcomes of men and women, Green (2006) suggests that programs would not only be most likely more cost effective, but mixed-gender treatment programs may be a positive option for both men and women seeking treatment (p. 61).

Relapse and Harm Reduction

Relapse is often seen as a transitional phase in recovery and not a failure (Barrett & Marlatt, 1999, p.177), however DeJong (1994) asserts that programs fall short when it comes to completely assisting those in recovery as relapse occurs due to the failure to develop sufficient coping skills (Gruber et al., 2001, p. 270). "In general past efforts have been refinements of primary treatment including posttreatment 'booster' sessions, use of pharmacotherapies to reduce drug cravings, crisis intervention, unstructured continuing-care groups, and referral to self-help groups" (Gruber et al., 2001, p. 270). Thus, there is disagreement about the acceptance of relapse as an accepted part of recovery.

In relation to relapse prevention, Gruber et al. recommends that in order to attain abstinence, one must remove or reduce factors, both personal and environmental, that could trigger their drug abuse. This may seem logical, however, Wallace (1994) recommended that treatment counselors should not require women in recovery to discontinue relationships with former drug dealing partners, as this could result in them going through treatment alone, which could be more harmful than remaining in contact with other friends and family. So, even though a woman in substance abuse treatment should attempt to separate themselves from drug and alcohol influences, severing all connections may put a woman at greater risk of unsuccessful recovery.

An opposing view to an abstinent recovery process is harm reduction as an approach to recovery, which works to meet the substance abuser ‘where they’re at’ in order to promote change in their lives (“Principles of harm reduction”; Barrett & Marlatt, 1999, p.177). According to the Harm Reduction Coalition, “harm reduction is a set of practical strategies that reduce negative consequences of drug use, incorporating a spectrum of strategies from safer use, to managed use to abstinence” (“Principles of harm reduction”). This concept is different from relapse in that it reduces the risks and harm of the addicted mother’s substance of choice as well as the risks involved when using the substance. It is essential to keep in mind that, "change is process oriented and gradual, and success is not defined as a final outcome but movement in the direction of less risk and harmful consequences to the client" (Barrett &Marlatt, 1999, p. 177).

Family Services

McMahon & Luthar stated that mothers participating in substance abuse treatment programs want to be good mothers (as cited in Carlson, 2006, p. 102), yet these women

often do not have the knowledge of healthy family patterns and as a result they may feel confused about normal child and family development (Liles & Child, 1986, as cited in Davis, 1994, p. 406), thus resulting in their children being removed from the home. Additionally, dysfunctional relationships are often a reality for substance abusing women, so it is essential to address issues concerning intimacy and sexuality in relationships in order to achieve healthy relationships and family life (Davis, 1994, p. 406). Thus, in order for these women to strive to be the good parents they want to be, they need to be provided with the knowledge and education regarding what constitutes normal family development and patterns as well as parental skills (Davis, 1994, p. 406).

Cultural Competency

Cultural sensitivity and competency has already been recognized as a strong value in treatment recovery programs, such as programs with clients from African American and Latino cultures. However, there is not just one cultural group of African-Americans that need to be considered in treatment programs, but rather there are three: African-Americans descending from African slaves born in the United States, African-Americans descending from African slaves in the Caribbean who have migrated to the United States, and lastly African-Americans born in Africa and have immigrated to the United States (John et al., 1996, as cited in Putt, 1999, p.37). If a treatment center is going to strive for cultural competency, as it should, it is essential that these different subcultures be addressed, considered, and understood as they contain varying cultures within each other (John et al., 1996, as cited in Putt, 1999, p.37). "The Hispanic population is also heterogeneous with subcultures of Mexican Americans, Puerto Ricans, and Cuban Americans" (Putt, 1999, p.39). Within these sub-cultures, of a race for example, values,

behaviors, and attitudes differ, which a treatment counselor needs to be aware of in order to provide effective treatment (Foulks & Pena, 1995, as cited in Putt, 1999, p.37). Additionally, contributing factors to substance abuse can vary from one culture to another, such as common contributing factors of substance abuse amongst African Americans include “under education, unemployment, underemployment, hopelessness, dysfunctional families, and other indices of poverty" (John et al., 1996, as cited in Putt, 1999, p.38). Thus, while cultural competency is an obvious aspect to incorporate into a treatment recovery program, it is crucial to examine the subgroups and subcultures within the diverse populations of a treatment program in order to better understand contributing factors of addiction, values, and cultural practices.

Causes of Substance Abuse

There are various biological causes and influences of substance abuse, but societal and environmental causes also play an essential role. Former trauma, abuse, mental disorders, or poor development into adulthood are some of the prominent causes of addiction. Studies have shown that trauma is widespread amongst members of outpatient substance abuse treatment programs (Fullilove, Fullilove, Smith, Winkler, Michael, Panzer, & Wallace, 1993, as cited in Carlson, 2006, p. 99). A second common cause of substance abuse is a history of some type of abuse: “numerous studies have found that a majority or substantial minority of addicted women, in both treatment and non-treatment samples, have sexual abuse and/or physical child abuse in their backgrounds” (as cited in Carlson, 2006, p. 99). A third cause is the co-existence of a mental disorder, which is commonly depression, anxiety, or post-traumatic stress disorder (PTSD) (U.S. DHHS, 1999, as cited in Carlson, 2006, p. 100). These issues are often not apparent when

someone is using drugs or alcohol, but they become vividly apparent once one stops and begins recovery (Carlson, 2006, p. 100). A study found "that up to one-third of all women with alcohol problems may have a primary diagnosis of depression" (Lex, 1994, p. 313). Lastly, those involved with substance abuse also may have other developmental impairments, both emotional and societal, such as poverty, having children too young, being a single parent, homelessness, or participating in criminal behavior such as prostitution (Connors et al., as cited in Carlson, 2006, p. 102). In a study, “most women felt that their heavy alcohol consumption was a legitimate response to personal problems and did not perceive that heavy intake might further complicate their problems” (Lex, 1994, p. 310). Therefore, in addition to the biological causes of addiction there are numerous other societal and environmental triggers for substance abuse in women.

In conclusion, there are a variety of approaches to treatment programs that incorporate different values and methods of treatment recovery. Gender-specific treatment programs have identified women-specific issues that cater to women’s needs, however mixed-gender programs have also recorded successful recovery. Additional approaches to treatment also include relapse prevention as well as harm reduction; both varying approaches to promote successful recovery. Lastly, understanding an addict’s background, from cultural influences to environmental influences, allows a treatment program and their staff to provide their clients with better services and as a result a better recovery.

Hypothesis

The literature and research seems to indicate a link between substance abuse and child maltreatment. The need for a substance abuse treatment program that can best

address substance abusing mothers is essential for effective recovery and reunification. Given the goal of this social service agency to remove obstacles and barriers for women seeking substance abuse treatment, it is hypothesized that substance abusing mothers will more effectively engage in treatment by accessing a comprehensive program with the goal of reunification. Additionally, this hypothesis asserts that the comprehensive model of this agency connects recovery with visitation and the mothers' goal of reunification, thus making substance abuse recovery more attainable. Through the advancements of this substance abuse treatment program, social workers are able to work more effectively and efficiently with the biological mother, children, and foster parents through the process and work involved in reunification.

Methodology

Sample

This study aims to explore and develop knowledge on what women with children in state care want out of a substance abuse treatment program as well as what barriers they have faced in accessing treatment. The sample for this study is a convenience sample of eleven women, ages 19 to 41 years old, involved an outpatient substance abuse recovery program and whose children are also currently in state foster care. The number of children for each participant ranged from one to six and the ages spanned from five months to ten years old. Questionnaire and consent forms were distributed by, and returned to, the clinicians and recovery coaches in the program. Completed questionnaires were placed in sealed envelopes and returned to the researcher for analysis.

Data Gathering

Participants are provided with a cover letter, which stated the purpose of the study and how the data will be used. Other aspects described were confidentiality, anonymity, voluntariness, and that there are no expected risks involved in participation. Lastly, the letter explained to the participant that through the completion of the questionnaire, they gave their consent. Contact information was given in case the participant should have to contact the researcher. The consent form is shown in Appendix I.

Instrument

Past substance abuse recovery experiences and new expectations were measured with a questionnaire that was designed for this particular study. The questionnaire contains five questions ranging from open ended to multiple choice options. Demographics collected included age, number of children, and the ages of the children. Two questions focused on the participant's past recovery programs and a final question asked what the participant would like to see in this recovery program. At the end of the questionnaire, participants are encouraged to expand on what they would like to see in a recovery program. The questionnaire is shown in Appendix II.

Data Analysis

Data collected from the questionnaires were be analyzed to decipher common obstacles and barriers women have faced when accessing treatment programs. Additionally, responses assessing what women would want to be included in a recovery program were also examined to determine what types of programming would work best for this population. Any additional qualitative responses were evaluated to enrich and contribute to the findings.

Results

The data collected from the completed questionnaires were analyzed using the computer program SPSS. The results of this questionnaire were comprised of a population of eleven women ranging in age from 19 to 41 years old. The number of children each participant had also contained a wide range of one to six children per participant, with a mean of 2.73 children per participant. The data showed that five of the eleven participants have previously been involved in substance abuse recovery programs, of which all were outpatient programs. Even though, the other six participants have not had previous experience accessing recovery programs, they still provided feedback regarding their current obstacles. Table 1 depicts the results of this question focusing on the obstacles participants have encountered when accessing recovery programs. Results showed that fear of DCYF involvement and transportation were the most indicated on the list of potential obstacles, with costs of programs and wait lists close behind. Lack of support throughout recovery, lack of child care, inconvenient program hours, and diversity issues were also identified as barriers.

Three participants also utilized the “other” option for the question in Table 1. Another barrier identified by a participant in this section noted that “conflicts with other participants” had been a problem for this participant in the past. Additionally, another woman added that methadone was “a pain”. Lastly, the third participant wrote, “[Agency] has provided the least amount of barriers in terms of finding support. I feel very confident and secure with each staff member I work with and teachers of childhood discipline. [Agency] is a great welcoming resource with no placement of time constraints.” This participant did not identify any specific barriers they encountered, however they provided

valuable feedback for this program. Additionally, the participant pointed out that there was not an option to indicate that a participant did not encounter any obstacles when accessing treatment.

Table 1: What have been some barriers, obstacles, and deterrents to recovery programs that you have experienced?

Barriers Frequencies

		Responses		
		N	Percent	Percent of Cases
Barriers	Cost of programs	3	15.0%	50.0%
	Transportation issues	4	20.0%	66.7%
	Wait lists	3	15.0%	50.0%
	Lack of support throughout recovery	1	5.0%	16.7%
	Lack of child care	1	5.0%	16.7%
	Inconvenient program hours	1	5.0%	16.7%
	Fear of DCYF involvement	4	20.0%	66.7%
	Diversity Issues	1	5.0%	16.7%
	Other	2	10.0%	33.3%
	Total	20	100.0%	333.3%

In regards to what participants thought would be most helpful in a recovery program (displayed in Table 2) recovery with fun activities, such as barbeques, was selected by the largest amount of participants. The second most frequent response from participants indicated that work to build natural supports, recovery with parenting groups, yoga/meditation, and spiritual support would be beneficial in their recovery.

Additionally, education about addiction, women's recovery groups, recovery with exercise, and one-on-one treatment with a staff member were indicated twice by participants. Lastly, a participant also indicated that support throughout recovery would be helpful for them during this process.

Table 2: What kind of recovery program would be most helpful to you?

Recovery Programs Frequencies

		Responses		
		N	Percent	Percent of Cases
Recovery Programs	Education about addiction	2	7.4%	25.0%
	Work to build natural supports	3	11.1%	37.5%
	Recovery with parenting groups	3	11.1%	37.5%
	Women's recovery groups	2	7.4%	25.0%
	Recovery support with fun activities	4	14.8%	50.0%
	Recovery with exercise	2	7.4%	25.0%
	Yoga, meditation	3	11.1%	37.5%
	Spiritual support	3	11.1%	37.5%
	Support throughout recovery	1	3.7%	12.5%
	One-on-one treatment with a staff member	2	7.4%	25.0%
	Help with ____	2	7.4%	25.0%
	Total	27	100.0%	337.5%

A last option for the second question is for a participant to fill in a blank line after the words “Help with” in order to allow participants to express something that may not have been provided as an answer. Two participants took advantage of this option for this question. One noted that, “help with life coaching and restructuring” would be a beneficial aspect for their recovery. The other woman wrote that she felt that “help with private doctors” would be useful for her. Lastly, the questionnaire ended with an optional open-ended question asking to “Please write any additional feedback about what you would like to see in a recovery program.” Only one participant took advantage of this space, but wrote very valuable feedback for the program: “How a sober life can be fun. Where to find support recovery and how to navigate the health care system.”

Conclusion

The initial purpose of this study was to identify and explore the barriers that women in substance abuse recovery face when accessing treatment programs. This group of women is unique in that they are also dealing with the removal of their child or children, and through this recovery program they are working on reunifying with their children as well as working on their substance abuse recovery. Additionally, this study sought to understand what factors would be most beneficial for these women in their recovery process and reunification with their children and families. The results of this study revealed some beginning understanding of what women in recovery are feeling and experiencing, as well as what they need.

In regards to the responses received, they closely follow what is described in the literature. The three main barriers identified by participants in this study included transportation, fear of the Department of Children, Youth, and Families (child welfare

system) involvement, the cost of programs, and wait lists, all of which support what the literature has presented. Transportation can also be an obstacle for clients when accessing treatment programs (Women and Additions Taskforce Training, November 13, 2009). However, in response to this barrier to recovery, this particular program will provide the necessary transportation for clients if they are unable to access or provide it themselves. This small logistical gesture allows a client to stay engaged in services and work on their recovery. Additionally, poverty was indicated in the literature as a leading cause of failure to access treatment, as it influences the cost of programs, transportation, child care, and more (Rockhill et al., 2008, p. 76). In addition to the cost of programs, poverty can narrow the options of a treatment program, which often leads to long waiting lists. This particular program that was studied is free for all individuals and if the program exceeds the maximum amount of clients, then the program plans to engage a potential client with a recovery coach until they are able to take them on as a full client. This approach is essential as evidence has shown that it is very difficult for someone to acknowledge their substance abuse, and then women often struggle with shame and guilt as well (Beckman, 1994; Janikowski & Glover, 1994; Magura & Laudet, 1999; Nelson-Zlupko et al., 1995; Reid, 1996, as cited in Carlson, 2006, p. 103). Therefore, this initial connection to resources, even while on a waiting list, will greatly improve their chance of success and accessibility to treatment because the waiting period allows someone to change their mind about seeking recovery (Ebener & Kilmer, 2003, as cited in Rockhill et al., 2008, p. 65).

Another focus of this study concentrates on what these women would find most beneficial in a recovery program. Identified most by participants was recovery support

through the center that involves fun activities, such as barbecues and other social gatherings. These types of events also may allow the clients to meet others in similar situations, and find support and strength through other clients (Magura, Laudet, Kang & Whitney, 1999, as cited in Carlson, 2006, p. 109). Thus, the importance of having various support systems was demonstrated by both the participants as well as in the literature. Consequently, working on building natural supports was also indicated by participants in this study as a key factor that they felt would be helpful through their recovery process. The literature reported similarly as women are less likely to have their partner support them through recovery (Kane-Cavaiola & Rullo-Cooney, 1991, as cited in Rockhill et al., 2008, p. 80). It is essential to try and connect women with support systems, as they are likely to not complete treatment if they attempt it alone (Wallace, 1994, p. 92). This is also shown through participants' interest in both one-on-one treatment with a staff member as well as recovery with parenting groups, which both provide constant support systems for these mothers. The interest in parenting groups also reiterates that, despite their indications of child maltreatment, these mothers want to be good parents and are willing to work on improving that (McMahon & Luthar, 1998, as cited in Carlson, 2006, p. 102).

Additional types of supports that were identified by more than one participant were yoga/meditation and spiritual support. Spirituality is a large part of many cultures, especially in African American cultures where spirituality is a significant support system (Lewis, 2004, p. 469). Therefore, participants in this study support the literature that spirituality is an important source of support for women in recovery, as well as other types of practice such as yoga and meditation.

Strengths and Limitations

The sample size of this study was small so generalization cannot be made to the larger population. There were various obstacles that were encountered which lowered the response rate. These included the questionnaires that were handed out to recovery coaches and clinicians who were instructed to pass them out to any female clients enrolled in the program. Every client has both a clinician and a recovery coach assigned to them for the duration of their case and often through miscommunication between these two staff members, the questionnaires were not completed for every client. Additional obstacles encountered included clients disengaging in services, cancelling appointments, and time constraints. The clinicians and recovery coaches also accompany clients to visitation with their children, in which they found that the parents were very protective of their time with their children and did not want to forfeit any time with them, so they were unable to fill out a questionnaire for several sessions and sometimes not at all. Therefore, this study was not being able to reach out to the entire female client population of this program.

Despite some of these limitations, strengths of this study were found in the diversity of the clients that were able to participate. The age range of women spanned over twenty years, from age 19 to 41 years old. Additionally, the amount of children each participant had also had a wide range from one child to three participants each having six children. This broad spectrum of demographics allows the viewpoints of women in all different stages of their life to express their experiences as well as what they find will benefit them the most.

Implications for Further Research and the Social Work Profession

Further research is needed in various aspects of this subject area as the obstacles and accessibility barriers change over time as well as from one community to another. It would be valuable for an agency or program to conduct a similar study to explore what the clients of their community find are issues as well as what they feel would be most helpful. This study was comprised of a small sample; therefore it would be beneficial to further explore a larger female population in this community. Additionally, this particular study did not require the specification of race, ethnicity, or cultural background, all of which could greatly affect both recovery accessibility as well as what each population would find most helpful in their recovery process.

The Code of Ethics from the National Association of Social Workers states, “Fundamental to social work is attention to the environmental forces that create, contribute to, and address problems in living” (National Association of Social Workers, 1996, p. 1). Therefore it is essential to continuously reevaluate the environmental forces on a particular population in order to provide the best services and programs possible. The social work profession also works with a wide variety of cultural groups ranging from race to gender to age, so it is important for social workers to acknowledge the implications of these cultures not only on their everyday life but also in the way that they access and utilize services. One woman from a specific cultural group may approach recovery vastly different than another, therefore it is vital to apply this to practice and explore where a client is coming from and what they require from their social worker.

In conclusion, this study sought to explore feedback from women in a substance abuse recovery program in order to establish the best practices, as well as address any accessibility concerns the clientele of this community may have. This population is

unique as they are also coping with the removal of their children and trying to establish how and what they can do to be reunified with them. Evidence has shown that substance abuse greatly influences child maltreatment (Carlson, 2006, p. 101), so it is vitally important to reach out and give these women the best chance at recovery in order to reunite their families. Therefore, the collected responses from this study have provided some preliminary data on a few of the initial concerns of these women as well as how this program can best serve this substance abuse recovery community struggling to bring their lives and families back together.

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Appendix I

February 1, 2010

Dear Participant,

I am a senior social work student intern. I am conducting a study for my senior thesis which explores what women with children in DCYF care are looking for in a substance abuse recovery program. Enclosed is a short questionnaire about your past recovery experiences, if any, as well as what you would like to gain from working with this program.

There are no expected risks associated with participating in this research study. The questionnaire only takes a few minutes and participation is voluntary. This study is also confidential and anonymous.

Your completion of this questionnaire indicates your consent to this voluntary and confidential study.

If you have any questions or concerns please contact me at _____ or email me at _____.

Thank you very much for your time and participation.

Sincerely

Michelle Larkan

Appendix II

Client Questionnaire

1. Age: _____

2. How many children do you have? _____

Children's ages: ____ _____ _____ _____ _____ _____

3. Have you participated in a substance abuse recovery programming/treatment before this one?

Yes _____ No _____

IF yes: ☐ Outpatient ☐ Inpatient/Residential ☐ Both

a. What kind of program was it? (i.e. 12 step program, support group, home based, etc)

b. How many times have you been enrolled in a recovery program? How long were you enrolled in each program?

Times: _____

Program 1: _____

Program 2: _____

Program 3:_____

c. If you did not complete the program, why did you leave early?

4. What have been some barriers, obstacles, and deterrents to recovery programs that **you** have experienced?
Circle **all** that apply.

a. Cost of programs
b. Transportation issues
c. Wait lists
d. Lack of support throughout recovery
e. Lack of child care
f. Inconvenient program hours
g. Fear of DCYF involvement with your child
h. Gender issues - not sensitive to women's issues
i. Diversity issues – not sensitive to minority issues
j. Other _____

5. **What kind of recovery program would be most helpful to you?**
Circle **all** that apply.

a. Education about addiction
b. Work to build natural supports (i.e. friends and family)
c. Recovery with parenting groups
d. Women's recovery groups
e. Recovery support with fun activities (i.e. Barbeque, movies, game night)
f. Recovery with exercise
g. Yoga, mediation
h. Spiritual support
i. Support throughout recovery
j. One-on-one treatment with a staff member
k. Group meetings such as Alcoholics Anonymous, Narcotics Anonymous, and/or any other 12 step program
l. Help with _____
m. **Other**_____

Please write any additional feedback about what you would like to see in a recovery program.

_____

_____

Thank you!