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for Women's Health

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Apprehensions

Barriers to Treatment for Substance-Using Mothers

By Nancy Poole
and Barbara Isaac

British Columbia
Centre of Excellence
for Women's Health

Report available
in alternate formats



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Centre of Excellence
for Women's Health**

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Women's Health Reports

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Abstract

This research study explored the barriers and supports encountered by women at the point of entering care at five types of addictions services in two distinct British Columbia locations (Vancouver and Prince George). Forty-seven women who were pregnant and/or parenting children under age 16, and who had problems with alcohol and/or other drugs were interviewed. Their responses create a “snapshot” of women’s entry into the alcohol and drug system of care from both southern (urban) and northern (small city and rural/remote) regions. Their responses illuminate the importance of recognizing women’s commitment to their children as well as their distinct needs as mothers when addressing their substance use problems.



No other Canadian studies that specifically addressed barriers for pregnant and/or parenting women were located prior to this study.

Background on Barriers to Addictions Services for Women

Barriers to women's access to addictions services have not been extensively researched or described in addictions literature. In part, this may be due to the methodological challenge of reaching those who do not directly access care for their substance use problems. Despite growing public interest and media focus on the prevention of Fetal Alcohol Syndrome and other alcohol- and drug-related developmental disabilities, no other Canadian studies that specifically addressed barriers for pregnant and/or parenting women were located prior to this study.

The work of two American experts, Sharon Wilsnack and Linda Beckman, has grounded the understanding of barriers to treatment for women in North America. Wilsnack (1991) reported on an extensive survey conducted by the Association of Junior Leagues with representatives of alcohol authorities, treatment centres and community "gatekeepers" in 39 communities across the U.S.A. (2500 interviews in total). In this 1985-88 survey, a strong consensus emerged from these three groups that the most serious barriers preventing women from accessing services were personal denial, responsibility for care of dependent children, and family denial.

Beckman (1994) offered an expanded framework for understanding barriers to treatment for women: she characterized barriers as internal (such as denial, fear of stigmatization, concern about leaving children, guilt and shame) and external (both interpersonal and structural). The most significant interpersonal barrier she recognized was opposition by family and friends. Zelvin (1999) concurs: "relational issues are interwoven with the onset and progression of addictions in women and, unless addressed, can prevent women from receiving treatment, establishing and maintaining abstinence, and achieving optimal recovery" (p. 10). Beckman also identified key structural barriers ranging from inadequate training of health professionals (resulting in lack of identification and referral of women) to a lack of women-sensitive treatment and a lack of economic resources.

Particular care was taken to listen for clues about how the attitudes and responses of others had a positive impact.

Finkelstein, Kennedy, Thomas and Kearns (1997) identified eight barriers to treatment for women, based on a review of American literature. These included: lack of early identification by professionals; lack of childcare and access to children's services; lack of residential programs that can accommodate mothers and their children; lack of transportation to and from addictions services; lack of safe, drug-free housing; lack of services sensitive to the needs of underserved populations; inadequate public funding; and staff attitudes that women are "sicker" and less likely to recover than men. This work also informed the research questions for this study.

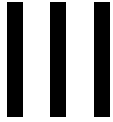
In this research, particular care was taken to listen for clues about how the attitudes and responses of others had a positive impact on women's entry into care for substance misuse. In telling their stories, participants often revealed that the timely support of a single individual – an alcohol and drug counsellor, a physician, a family member – was pivotal. They also revealed clues regarding the underlying issues with regard to their substance use, events also noted by Zelvin (1999), such as loss of significant relationship(s) (for example, children), losses from suicide or death, and so on. Paradoxically, for some women such losses were also the

impetus to enter treatment. The experiential knowledge disclosed by participant women guides the recommendations for further research and for actions to improve early identification and ways of working with women who are pregnant and parenting.

The design of this research was influenced as well by a unique study on drug-using pregnant women, the California Perinatal Needs Assessment study (Brindis, Clayson and Berkowitz, 1997), which was conducted with 401 pregnant women, most of whom had not been in treatment for substance misuse. They found that three-quarters of those surveyed did not want treatment, citing barriers that were reported as personal ("I can cut down on my own," 62%), informational (not being sure what a program would be like, 17.6%), and social (such as fear of legal problems as a consequence of identifying as using drugs while pregnant). An important finding was that women who wanted to be in treatment (yet were not), gave similar reasons for not seeking help as were given by the women who did not want to be in treatment.

A literature review on gender differences in barriers to help-seeking undertaken by Renate Schober and Helen Annis of the Addiction Research Foundation of Ontario

stressed how such barrier constructs may provide a useful framework of intervening in the help-seeking and addictions-change process. The implications of the client- and program-related barriers identified in this study are considered in the final section.



The overriding concern was to expose and validate, qualitatively and quantitatively, women's experiences.

Research Methods

Tierney and Lincoln (1997) suggested that “the desire to create change, to lessen oppression or assist in the development of a more equitable world sets up a different research dynamic” (pp. viii, ix) and must be paramount in any research involving marginalized women. Accordingly, this research focuses on women’s experiences, with the goal of ascertaining and depicting their lived knowledge of the societal and institutional responses to pregnant women and mothers. Similarly, Reinharz’s (1992) belief that feminist research should commit to “making the invisible visible, bringing the margin to the center, rendering the trivial important, putting the spotlight on women as competent actors, (and) understanding women as subjects in their own right” (p. 248-249) guided the research design, analysis and documentation. In the discussion of interview responses, women’s lives are presented in context and both the range of responses and common themes are communicated.

The decision to use both quantitative and qualitative methods was an attempt not to resolve paradigm differences but to creatively use “more informed and sophisticated” (Guba and Lincoln, 1994, p. 116) research methods. This approach to inquiry responds to the need for open and informed application of methodologies with regard to social justice issues, rather than dichotomizing approaches to inquiry. Indeed, this aspect of the research was congruent with the desire to highlight the complexities of the lives of the participants in our study. The overriding concern was to expose and validate, qualitatively and quantitatively, women’s experiences of the absence of options to treatment and lack of recognition of their needs as mothers.

The methodology was also guided by the following:

An understanding of the experience of substance misuse

The understanding of the experience of physical and emotional discomfort, as well as problems with cognitive functioning associated with withdrawal and early recovery, led to a limiting of the number and complexity of the questions asked. Only two key open-ended questions on barriers and supports were used, and the interviewers were asked not to do

The interaction was planned to be as welcoming, easy, straightforward and short as possible.

extensive probing. Following the open-ended questions on barriers, a list of barriers was provided and participants were asked to indicate which of these barriers were applicable to them. This was done to ensure that the full range of what might be considered barriers would be comprehended. Since the study was attempting to reach women who were newly requesting help, and who were likely to be tentative and unsure, the interaction was planned to be as welcoming, easy, straightforward and short as possible.

Priority was placed on ensuring that a diverse range of women's experiences was included.

A commitment to empowering all those with a stake in the issue being studied

The study took place in the context of high-profile media coverage of cases of women struggling with addiction and parenting, and major restructuring of the British Columbia addictions "system of care". Addictions service providers expressed particular concern for women's care and demoralization about their own ability to have a positive impact on altering the system to take women's needs into account. Their "insider" knowledge was invaluable to the research process: they helped us recruit women to participate in the study, augmented the design of the questions, and reviewed the preliminary results. The latter "reaffirms their active participation and their

desire to make the findings meaningful, accurate, and credible...and to substantiate findings...they know their worlds" (Morse, 1994, p. 108). It was hoped that their involvement would provide a forum for collectively naming and acting on their concerns and their own feelings of discouragement, as well as helping ensure that the research plan was both solid and relevant. As Lather (1991) suggested, the research process "re-orient, focuses and energizes participants toward knowing reality in order to transform it" (p. 68).

An interest in identifying and honouring the diversity of women's experiences

While this research was a small, exploratory study that did not involve enough women to do a statistical analysis of differences between subgroups of women, priority was placed on ensuring that a diverse range of women's experiences was included. The experiences of women coming for help in northern communities around Prince George and in the large, urban Lower Mainland area of British Columbia were of interest. The experiences of women coming to a variety of types of services – outreach services for pregnant women, detoxification services, outpatient counselling, day programming and residential treatment/care – were of interest, recognizing that women's

It was important to shift the focus of discussion and action from maternal/fetal conflicts and blaming individual women, to how systems can better provide women-centred care.

access to different services depends on their circumstances as mothers and substance users. The commitment to holistic inquiry and diversity also meant that the interviewers, agency representatives, and even transcribers, were chosen from varied age groups, cultures, sexual orientations, geographical regions and abilities.

A belief in research as a vehicle to support change in systems and policies

Even small studies such as this one can serve to advocate increased understanding of women’s experiences and illuminate ways to make systems more responsive to women’s needs. This research was done in the wake of a Supreme Court of Canada case regarding a mother with a serious substance use problem who did not get the help she needed (Winnipeg Child and Family Services (Northwest Area) v. G. (D.F.)). In this context, it was important to shift the focus of discussion and action from maternal/fetal conflicts and blaming individual women, to how systems can better provide women-centred care.

It is indeed challenging to engage women who are experiencing barriers to treatment before they have surmounted these barriers. In this study, in order to describe barriers to treatment for women

who had not yet entered treatment, women were recruited from detoxification and “pregnancy outreach” programs in each city. Pregnancy outreach programs are accessible, non-judgemental, community-based services that provide nutritional and health counselling and referral, supplemental food, and peer support programming for women at risk of having children affected by their use of substances during pregnancy. Women enter detoxification services either voluntarily or involuntarily, and may go on to access treatment services or not, following management of their withdrawal symptoms.

Study participants were also recruited from services providing outpatient counselling and day treatment for alcohol and drug problems, and from residential treatment centres and supportive recovery homes. These women had only recently begun treatment at these services; hence their knowledge of the barriers and supports experienced when accessing this care was very immediate.

Interviews were conducted in Vancouver and Prince George between February and May 1998. Forty-seven women who had problems with alcohol or other drugs were interviewed. All of these women were pregnant and/or mothers of children under the age of 16 and requested

service in February 1998. The study participants were recruited by service providers in 10 agencies providing the following types of service: pregnancy outreach programming, detoxification, outpatient counselling, residential treatment, and supported housing. All the interviews took place at the centres where study participants were accessing care.

Table 1 provides a summary of the composition of the planned and actual study sample.

Typically, interviews took approximately 45 minutes and involved an open-ended question about barriers to treatment, a structured question (in which participants indicated which barriers among a list of 33 possible barriers to treatment applied to their situation), and an open-ended question about supports when accessing treatment. While the primary interest was in hearing women describe their paths to addictions services in their own words, past experiences with

Table 1: Study Sample Composition

Program type	Location	Planned number of study participants from this level of service	Actual number of study participants from this level of service
Pregnancy outreach	Vancouver	5	5
	Prince George	5	5
Detoxification	Prince George	5	5
Outpatient counselling	Vancouver	5	2*
	Prince George	5	10*
Day treatment	Vancouver	5	5
	Prince George	5	0**
Residential treatment	Vancouver	5	5
	Prince George	5	5
Supportive recovery programs	Vancouver	5	5
	Total	50	47

* Service providers from the governmental services that provide outpatient counselling in Vancouver were unsuccessful in recruiting five women who met the criteria.

**The day treatment program planned during the time period of the study was postponed, so the women who would have entered day treatment entered outpatient counselling instead.

asking women about barriers suggested that structured questioning would complement open-ended questions and ensure that women understood “barriers” as a broad term and not a narrow category of structural issues. The structured question included both barriers identified in the literature and those that the service providers involved in the study viewed as relevant to women who use their services. The interview questions are included in Appendix 1.

Participants were also asked to complete a two-page demographic questionnaire about their living arrangements, education, employment, finances, relationship status, children, cultural background, problem drugs and health status. Assistance was given by the interviewers for those women with literacy problems. These questionnaires provided the information about study participants that is presented in Table 2.

Table 2 (Series): Study Participants: A Profile

Cultural Background	North	South	Total
Aboriginal	60%	18%	40%
Caucasian	36%	59%	47%
Other	-	9%	4%
Unknown	4%	9%	6%
Motherhood/Status	North	South	Total
Pregnant	24%	9%	17%
Had Children Living with Them	92%	91%	91%
Current Custody Issues	36%	23%	30%
Given Up Custody	36%	36%	36%
Lost Custody	48%	23%	36%
Living Arrangements/Stability	North	South	Total
Living Alone	12%	18%	15%
Living with a Partner	40%	23%	32%
Living with Children	36%	55%	45%
Living with someone with an alcohol/drug problem	52%	14%	34%
Moved more than 3 times in the past 3 years	60%	72%	65%
Level of Education	North	South	Total
Less than Grade 8	12%	0%	6%
Some High School	48%	50%	49%
High School Graduate	12%	9%	11%
Some Technical College	28%	23%	26%
Tech/College Graduate	-	9%	4%
University Degree	-	5%	2%
Number of Dependents	North	South	Total
None	48%	14%	30%
One to Two	36%	81%	58%
More than Two	16%	5%	11%
Employment Status	North	South	Total
Employed Full-Time	-	5%	2%
Employed Part-Time	4%	9%	6%
Unemployed	36%	50%	43%
Homemaker	32%	23%	28%
Student	12%	5%	9%
Not in the Labour Force	16%	5%	11%

Typical Occupations of the Study Participants:

- 53% of the women did not provide an occupation in which they were usually employed
- 13% of the women were involved in “service to the public” type of work such as waitressing and bartending
- 17% of the women said they had worked in a clerical role such as retail sales or cashier
- 5% were involved in seasonal work
- 3% were employed in illegal activities

Finances:

- 75% of the women stated their main source of income was from Social Assistance Benefits
- Other sources of income were from employment, Employment Insurance and the women’s partners
- 68% of the women interviewed stated that they had significant debt

IV

Research Findings

In order of frequency, the top five barriers identified in response to the structured questions were personal, followed by two structural (relating to the alcohol and drug system of care) barriers:

- shame (cited by 66% of study participants)
- fear of losing children if they identified a need for treatment (62%)
- fear of prejudicial treatment on the basis of their motherhood/pregnancy status (60%)
- feelings of depression and low self-esteem (60%)
- belief that they could handle the problem without treatment (55%)
- lack of information about what treatment was available (55%)
- waiting lists for treatment services (53%)

Tables 3, 4 and 5 (see Appendix 2) list the percentages of study participants who gave positive responses to the structured questions, grouping responses by region and by the type of service the women had accessed.

The top five supports offered by the women to an open-ended question on what supported their accessing treatment (in order of frequency mentioned) were:

- support provided by a wide range of professionals (cited by 77% of study participants)
- supportive family members (68%)
- supportive friends and people encountered in the recovery movement (47%)
- children as motivation to get help (47%)
- the alcohol and drug system of care working optimally, as a support (32%)

Three themes emerged most strongly from women's stories of their individual paths to addictions services. The interview findings have been organized around the barriers and supports related to these three themes:

- women's self-image and their particular responsibilities as mothers
- women's relationships with children, partners, extended families and friends
- women's relationships with people at potential points of entry to the system of care

V

Low self-image and low self-esteem are fundamental barriers to a woman's decision to try to find help for substance use problems.

Discussion of Key Findings

A. Self-Image and Context: “Common-Sense” Judgements of Mothers Who Use Drugs

“You get so used to having society look down on you that you think it’s going to be like that when you come to [addictions services].”

Such statements, repeated in a variety of ways in the interviews, revealed that low self-image and low self-esteem are fundamental barriers to a woman’s decision to try to find help for substance use problems. At the same time, this response shows how pervasive negative stereotypes about mothers who use substances influence women’s self-concept. Two-thirds of the study participants (66%) identified with the statement, “I was ashamed about having a problem with alcohol and drugs and having others know.”

“I don’t think anybody would actually want to spend time with me, to listen to me, to hear my stories.”

As exemplified in the above statement, 60% said that feeling “too worthless or depressed to get it together to go” was a barrier to accessing addictions services, and nearly as many (57%) expressed fear of how others would treat them because of their status as “pregnant or a mother who has a problem with drugs.”

“And once I told them my story, what would they think of me?...Because women aren’t supposed to do this kind of stuff. They’re just not. They’re considered dirty, ugly, filthy.”

In such statements, women made a direct connection between their self-image, societal judgements and accompanying denial that they needed help to address substance misuse problems. While such responses are often seen as “personal” (Beckman, 1994; Brindis et al., 1997), there are obvious connections between women’s self-judgements and the pervasive “common-sense” attitudes about women and substance use in society at large.

In response to the structured list, many women said, “I felt I could

A greater understanding is being built about how relationships with partners, children and extended families significantly influence a woman's self-esteem.

handle my problem myself" (55%) or "I felt I didn't really have a problem" (43%). Regional differences turned up in this set of responses, with participants from the northern region being more likely to identify denial as a significant barrier to accessing addictions services. Just over two-thirds of those interviewed in Prince George identified with the statement, "I don't really have a problem." In addition, these women's responses typically described family and community environments where substance misuse was commonplace and childhoods that were spent in alcoholic families. Again, the contextual factors greatly influenced a woman's understanding of herself and her substance use. Interestingly, women's comments on "I did not want my family to know" produced the largest regional difference: only 8% of the women from the north identified this statement as a barrier to treatment, compared with 59% of the women from the south. The majority of women who identified that they feared being judged by their families were not of First Nations descent, suggesting that such judgement may be more prevalent outside native communities.

Women fear that the child protection system will respond in an arbitrary fashion.

From research in the fields of family violence, sexual abuse and mental health, a greater understanding is being built about how relationships with partners, children and extended

families significantly influence a woman's self-esteem and her ability to recognize that change is possible. Perhaps less well known is how women experience the stereotypes and prejudicial attitudes encompassed in child welfare practices, the response of the criminal justice system to substance-using mothers, and attitudes and beliefs taken for granted among service providers and the women themselves.

"If I talked about having a problem, I was afraid of the way people would treat me because I'm a mother and using."

"Being scared of being judged... I don't like being judged."

Study data showed that women fear that the child protection system will respond in an arbitrary fashion and automatically apprehend their children on the basis of use alone, if they admit to needing help with drug use, especially for illicit substances. The majority of participants (62%) said, "I was afraid I would lose my children if I said I needed treatment." It appears that this fear was not unfounded: for example, 36% of the women had lost custody of one or more children, 36% had given up custody, and 30% had current custody issues. Such women were often caught in a "catch-22" situation of wanting and needing help with substance use problems in order to be better parents, but facing

the possibility of losing their children if they disclosed their needs to social service personnel.

Interview responses revealed differences in the experiences of women who sought different levels of care. For example, in the south, 80% of women accessing pregnancy outreach programs cited fear of the Ministry as a barrier, compared with 14% of those accessing outpatient counselling and 20% of those accessing residential treatment. The much lower rate of response for residential clients can be attributed to the fact that many of these women had already experienced having their children apprehended or had surrendered custody prior to entering treatment. Indeed, among mothers who came into residential treatment at the Aurora Centre (one of the Vancouver programs involved in this research study) in 1998, 35% had current custody issues, 27% had lost custody of a child and 37% had given up custody of a child.

Also noteworthy is the difference in response by women at the pre-treatment stage in the north (where the outpatient clinic remained a free-standing clinic) as compared to those from the south (where outpatient counsellors were located in Ministry for Children and Families offices alongside child protection workers). Fully 80% of the women

from the south, as compared to 40% from the north, indicated that fear of the Ministry was a barrier to seeking help. Indeed the Ministry-based outpatient counselling service in the south saw so few women who met the criteria for the study (were pregnant and/or parenting children under the age of 16) that they were unable to recruit five women over a one-month period and thus only 47 rather than 50 women were included in this study. That the child protection system was seen by the majority of the women in this study as likely to judge them “incompetent as mothers” contributed to women’s feelings of guilt and shame. Participants indicated that they felt deeply responsible for the well-being of their families, and that having to prove their abilities as mothers in ways that other women do not, often made it even more difficult for them to reduce their use or abstain from drugs.

In this study, internalised feelings were commonly identified as barriers to accessing addictions services, making it important to link these with the negative effect of existing stereotypes and responses to drug-using mothers and pregnant women. For example, feelings of shame seemed exacerbated by living in a small town, where the risk was greater that a woman going into a building used for addictions services would be seen by neighbours, friends or family.

Mothers who identify as having problems with substance use can be both responsible caretakers of their children and in need of care themselves.

Women who expressed shame often reported, as well, that their partner or other family members actively discouraged them from seeking treatment.

In order to support women's efforts to achieve and maintain sobriety, it must be acknowledged that mothers who identify as having problems with substance use can be both responsible caretakers of their children and in need of care themselves. The stigma of failure, even wickedness, that has surfaced regarding substance misuse by mothers and pregnant women makes keeping drug-use secret both a survival mechanism and a formidable barrier to getting help.

"I was ashamed, guilty and really angry at myself."

"I knew I had a problem and I was getting deeper and deeper in my problem, and I would push everybody away. Meanwhile, they were there to help me but, you know, I couldn't see it then. I thought I was too far gone. I was like rock bottom."

These findings highlight the need for a response that places personal barriers within the context of prevailing attitudes and practices. Addictions services would benefit from building on what is known about women's competency and commitment to parenting, rather than

perpetuating the existing negative stereotypes of mothers who use drugs.

B. Responsibilities as Mothers: "My Kids Are My Life"

As noted, women described their parenting role as one of the most problematic barriers to seeking help for alcohol and drug misuse. Their stories were anguished and poignant, no matter how matter-of-factly a woman related the loss and fears she experienced around childcare and custody. One woman noted: "I was afraid that the people I was talking to would come and take my baby away". Women's parenting role had a significant impact on their decisions to negotiate with various services and systems to ensure that their children would be safe and secure in their absence.

"Going to treatment and being without my children was a really scary thing. I was scared of leaving them for six weeks...well, I tried it before...I only lasted a week. Not even a week 'cause I couldn't stand being away from my kids. You know, my kids are my life. They are small children and I really didn't want them going to foster care while I came to treatment."

Interview responses indicate that women are extremely reluctant to leave their children, and that they

Women are clearly unwilling to leave children with caregivers who are not seen as supportive of the mother's continued parenting role.

Entry into treatment was often based primarily on their determination to regain custody of their children.

feel constrained by the extremely limited availability of addictions programs designed to accommodate mothers and their children. In response to the open-ended question on barriers to treatment, roughly half of study participants (49%) cited lack of childcare and nearly a third (32%) said they were unwilling, for a variety of reasons, to have others look after their children. Further, the majority (62%) were so fearful of losing custody that they were loathe to ask for information regarding childcare options which may have been helpful to them. Women are clearly unwilling to leave children with caregivers who are not seen as supportive of the mother's continued parenting role, and are also unwilling to accept offers of child care from family members whom they see as abusive or "in denial" about their own alcohol and drug-use problems.

Even for women who were willing to relinquish custodial responsibilities to the foster care system or to partners or family members while they accessed residential treatment, trustworthy and competent childcare was not readily available. Thirty-six per cent of participants identified with the statement, "I didn't have anyone to watch/take care of my children while I was at treatment." Both quantitative and qualitative data suggest strong links between the removal of responsibility for

childcare, whether voluntarily or involuntarily, and the timing of a woman's decision to access addictions programs and treatment.

The study participants revealed that entry into treatment was often based primarily on their determination to regain custody of their children. Without exception, women felt their children belonged in their care because, quite simply, they offered the love that their children needed. Women who lived with their children repeatedly cited separation anxiety as a major barrier. An overriding theme in women's descriptions of barriers was their perception that the Ministry generally does not take into account their need to maintain an ongoing relationship with their children. Women felt that the Ministry punishes them for substance misuse instead of focusing on how to help them, thereby meeting its mandate to act in the "best interests" of the children.

"[My child has] always lived with me...There was nobody to negotiate for me with his dad. I was feeling so ashamed as it was that I had no power, you know, and the boy had no power. Decisions were all made [by Ministry personnel] based on my alcoholism, not on what was good for the boy. Do you understand what I'm saying? I felt he should have been considered first; go from there."

One woman was told she had 30 minutes to find care for her children.

Interview responses included a handful of examples of disrespectful and perhaps even preventable interventions by child welfare workers. For example, one woman was told she had 30 minutes to find care for her children, who were subsequently removed. As well, there were questionable placement decisions that disregarded women's expressed concerns for the safety of their children. A small number of participants also voiced frustration at the seemingly arbitrary eligibility criteria adopted by services: one residential facility, for example, sets a limit of two children, which forced a woman with three children to access day treatment instead of the residential program that she wanted and felt she needed. However, more often women's experiences of childcare and custody issues as barriers were linked to feelings of shame and fear of the negative judgements of those who see the need for treatment as indicative of parental neglect or inadequacy.

A woman's network of significant relationships can be either an important source of support or a serious barrier.

In contrast, when women were offered non-judgmental supports that relieved them of responsibility for the care of their children – whether care was arranged through the Ministry, community-based services or family and friends – they gratefully accepted the chance to turn their attention to taking care of themselves.

The fundamental challenge posed by women's responsibilities as mothers is to expand childcare options for drug-using mothers, including greater involvement by partners and family whenever a woman consents, so that recovery is motivated by a desire to make positive changes rather than by coercion. In dealing with issues of childcare and custody, it is also important to build on a woman's determination and her love of her children, to break generational cycles of addiction in order to raise her children in an environment that one participant called "the normalness" of sobriety.

C. The Influence of Family Relationships

Interview responses suggest that early intervention and treatment may be strengthened by outreach to family members and community services. A woman's network of significant relationships can be either an important source of support or a serious barrier, delaying her movement through different stages of recovery (from self-identification of problems to entering treatment). Nearly all participants identified one or more of the following as influential in their getting treatment: partners, parents, siblings, other relatives and friends.

The information that drug-using mothers and pregnant women

A woman’s primary relationships and her home environment should be explored attentively when working with her on a plan to access support services and treatment.

revealed about their significant relationships affirms how women in our society experience family and close friends: relationships are interwoven, creating the fabric of daily life and recreating long-standing gender-specific inequalities. Partners exerted a great deal of power and control, and many women (30%) identified with the structured question, “My partner did not want me to get help.”

Given the broad focus of the interview questions, understanding of the often competing influences of women’s interpersonal relationships is far from complete. Enough has been learned, however, to assert that a woman’s primary relationships and her home environment should be explored attentively when working with her on a plan to access support services and treatment.

While just under one-third of participants (32%) identified living with a partner, the influence of partners was a recurring theme in the open-ended questions. More than half the women (52%) from the northern region were “living with someone with an alcohol/drug problem,” and one in three study participants talked directly about ways they perceived their partner as having actively prevented or tried to prevent them from getting help for alcohol and drug problems. Women most

often identified partners as barriers if they had experienced any or all of three behaviours: physical violence, threats and “guilt tripping” over child-care and custody or pressure to join their partner in using drugs. One woman said:

“Like he was trying to put a big guilt trip on me because we were supposed to both go to one [treatment facility], but my counsellor said it was best that I went by myself and he kinda made me feel bad for coming [to treatment].”

At times, attempts to control women were subtler, as partners shifted from initial support to resistance when a woman began to make choices about getting counselling and treatment. Women who were experiencing relationship violence and instability felt especially constrained from accessing services that required them to be away from their children. At the same time, abuse and threats compelled several women to flee to a safe place: and that act of leaving an abusive situation became the first step on their path to recovery. Paradoxically, coercive behaviours had the effect of supporting a woman to make positive choices.

“I don’t want to live a life being a drunk and a druggie. And also getting beat up by my old man and having my daughter stand there and look at her mom like that. I’ve been through

Women seemed to make the decision to get help in spite of their partners, rather than with their encouragement.

Families matter, even when women currently have little or no direct contact with family members.

Women talked about dealing with family members who ridiculed or minimized their desire to find help.

that pain and I've seen my mom go through the same pain...getting beat up and drinking her life away. It's hard."

For the most part, women seemed to make the decision to get help in spite of their partners, rather than with their encouragement. Those who experienced their partners as supportive cited a partner's own work on addictions and recovery, shared commitment to "saving" the marriage, financial assistance (for example, a partner's medical and benefit plan), and help in finding out what services were available.

The interview format used for this study does not allow detailed analysis of the extent of the influence of partners on a woman's entry to addictions services. However, what women related about their domestic relationships, and the frequency with which they described using drugs in the company of a partner or ex-partner, suggested that their living arrangements contributed to personal denial and exacerbated women's fears of abandonment and reprisals if they identified as needing help.

Families helped or hindered women from accessing treatment in as many ways as there were differences in the life histories of the 47 study participants. While it was impossible to identify all the family-connected

issues mentioned in the interviews, it can be said unequivocally that families matter, even when women currently have little or no direct contact with family members.

The structured statements about family members (other than partners) not wanting the woman to get help or actively trying to prevent her from getting help elicited only a 4% response. Yet women's answers to the open-ended questions on barriers and supports involved a wide range of negative and positive experiences with parents, stepparents, grandparents, siblings, aunts and uncles. Their stories offered both hints and profound awareness of the connections between their sense of self – as women and as mothers with substance misuse problems – and their childhood experiences. Growing up in families where drinking was prevalent and substance misuse problems were denied or otherwise not addressed was identified as a barrier by 23% of participants. Women talked about dealing with family members who ridiculed or minimized their desire to find help. Many were conditioned not to discuss their problems outside the family, deepening the shame already being experienced because of the stigma attached to drug-using mothers. In general, families can be seen as significant factors underlying most participants' feelings of low self-

Several participants described having an ongoing relationship with someone who was clean and sober, whether a relative or friend, as important.

esteem, shame and guilt. It was found, as well, that women who had experienced abuse as children were understandably unwilling to leave their children in the care of others.

“I didn’t want to leave the kids with [my husband]. But they are with him right now, and he’s in active addiction. But I’d had enough and I left. My mom and dad are going for custody of the children, temporary custody. And that starts tomorrow, which is real cool.”

It seems significant that when a woman was actively supported by a trusted family member – most often involving childcare or custody – she spontaneously described that support as being one of the most important factors that made it possible for her to access addictions services. Women cited as supports the encouragement and information they received from family members in recovery, as well as pragmatic forms of assistance such as childcare, money and transportation. Several participants described having an ongoing relationship with someone who was clean and sober, whether a relative or friend, as important. Women also talked about being motivated to seek help when they saw the difficulties family members and friends experienced because of substance misuse and denial.

“[My father] believed in me even when I was at my worst, and my stepmother was absolutely wonderful. She listened, she cried with me, she was just there. And my brothers... I’m very, very lucky to have the family I have, I think. All these people have taken a big part in my recovery, and I owe them all a thank-you.”

D. Asking for Help and Finding It

This section highlights the diverse points of entry into the system of care and the importance of a timely response to women’s personal readiness, which has been identified in the literature as one of the most serious barriers for women who are experiencing problems with substance misuse. Study participants’ experiences of accessing services ranged from crisis entry to a long, downhill “bottoming out” over a period of years. Most had limited involvement with the system of care (prior to arriving at the program where they were interviewed), although a small number of women had accessed detox and treatment services numerous times.

In response to the structured questions, 43% of study participants indicated they had had “bad experiences with getting help in the past.” Some described “cultural prejudice”, or having to “tell my story fifteen thousand times”. Other participants recounted that alcohol and drug

Fear and shame kept most study participants from seeking help for years.

counsellors, as well as others at points of referral to addictions services, were inconsistent in offering information on supplemental financial support for costs incurred as a direct result of seeking help for substance misuse. Financial barriers included costs for childcare, for personal items needed when away from home, and for transportation (both local travel to day services and distance travel to residential treatment, which typically required driving several hours to Prince George from communities scattered across the northern region of the province).

Although some women identified Ministry workers as helpful (for example by arranging for “comfort allowances” during residential treatment), more women said they were forced to rely on friends and family or seek financial help on their own. One woman described being accepted into a treatment program which was three hours away by public transit, then having to appeal to the Salvation Army for bus fare because her alcohol and drug counsellor had turned down her request for travel costs.

It is likely that at least some of these barriers result from poor communication and from women’s reluctance to specify the help they need because of their fear of negative judgements, rather than from prejudicial or

unreasonable policies. For reasons already discussed, fear and shame kept most study participants from seeking help for years, and kept them in conscious or unconscious denial. While it would be expected that social services and health professionals would be aware of this facet of women’s needs, this was not the case for many of the women in this study. Problems were also encountered at the initial stage of self-awareness: once women had resolved to get help, most said they simply did not know where to turn for information. The structured questions revealed that lack of knowledge: “I didn’t know what help was available” was one of the top barriers (57%), as was lack of knowledge about “what treatment would be like” (38%).

“I just didn’t realize how the system worked. There’s no real paper stating that this is the way you go about getting treatment. I thought that my doctor would take care of these types of things, as opposed to me having to research and find out how to do it. And I can see...someone who’s really suffering, how they would become very discouraged by the seemingly unavailable resources to them.”

Nonetheless, study participants had positive things to say about people they met at the outset of their path to recovery, identifying a range of

Participants had positive things to say about people they met at the outset of their path to recovery.

professionals working in the alcohol and drug system of care and the health care system as supports. Other supportive points of entry were the Elizabeth Fry Society, Cool Aid Society, Women’s Resource Centre, Native Friendship Centre, Alcoholics Anonymous and Narcotics Anonymous, probation services, and church groups. Interestingly, many women credited one particular individual within these services with motivating them and enabling them to access treatment.

Many participants identified trust issues and difficulties with establishing confidence with those in positions of “authority” as barriers in many different circumstances. Yet when the system of care worked well, help was offered and accepted. Women were referred to a continuum of addictions services and to community-based recovery support groups. Individual and group counselling was made available. One worker intervened with a native woman’s band council to secure financial help with treatment. A detox worker coordinated entry with staff at a homeless shelter to ensure that the woman had a safe place to stay until detox had a bed for her. The information women provided about finding help emphasizes the need for non-judgmental support after a relapse, and the value of advocacy.

“It’s just amazing. I just had to ask for help once and now I have this whole chain reaction with help...I’ve changed my friends. I’ve changed all my patterns. I went from sitting at home in front of the TV to going to the park with my children – not setting myself up to have a drink or to have a smoke is a big one. And now that I got a bus pass, I can ride all over the city and still not set myself up.”

VI

One step in the process of reducing stigma and shame is the adoption of caring service philosophies which welcome women into care.

Conclusion and Recommendations

This study was designed to enable women to reveal their experiences of accessing addictions services in British Columbia. The specific purpose was to identify practices and policies that would have a positive impact on women's ability to mother effectively while addressing their substance use. From the barriers and supports cited by the study participants, the following recommendations are offered for action in practice, policy and further research.

—☺ **Address stigma, shame and prejudice**

There is colossal work to do to change the pervasive attitudes that blame, shame and pathologize women with substance use problems. As this study has identified, these attitudes definitely deter women from seeking the help they need. One step in the process of reducing stigma and shame is the adoption of caring service philosophies which welcome women into care, no matter what their circumstances, or drug of choice, and honour their capacity to make decisions about their care.

Another critical step is to support increased understanding of substance use and recovery on the part of child protection workers and others in a position to make and support decisions regarding women's lives. Such understanding has been successfully created in service networks inclusive of child protection, addictions, violence, mental health, health care, vocational and other service providers that have the goal of developing collaborative approaches to serving women. While larger community-wide efforts to shift attitudes are also necessary, beginning with the services and gatekeepers to services is critical, given the role of gatekeepers in supporting women's entry into care.

—☺ **Ensure that information on treatment programming is widely available**

Making information on existing services for women more widely available is clearly a key strategy for reducing barriers. Plain-language information that answers frequently asked questions about location, cost, eligibility and referrals to addictions services needs to be made

Programs and services that serve mothers and their children together are desperately needed.

more widely available. The Alcohol and Drug Information and Referral Service's toll-free help line [1-800-663-1441] also needs promotion. Such information should be made available in doctor's offices, in Ministry of Children and Families and Ministry of Social and Economic Development (income assistance) offices, and neighbourhood and friendship centres, to name but a few. For women in small communities, privacy and confidentiality in the transmission of information is especially important.

—☺ **Support the role of “gatekeepers”, families and peers in helping women get to care**

Beyond helping gatekeepers shift their attitudes towards women who use to a more compassionate stance, there is need for gatekeepers to be actively supported in recognizing substance use problems, communicating with women about their use, and making referrals to treatment. Women in this study have identified how fear and shame cause them to hide their problems, even from themselves, and how professionals have helped support them in getting care. When training, cross training, and joint planning are done by health and social service professionals, not only are women and children better served, but opportunities for com-

munity-wide progress in changing attitudes and building service systems are created.

Practical support that could be provided by gatekeepers to promote women's connections to treatment includes transportation to the alcohol and drug service, or bus tickets/cab fare to the service. While budgets and current policies often don't allow for financial support of transportation to detoxification and treatment, it is clear from this study that such support (both when first considering attending a service, and when attending treatment) can greatly enhance access by women who have low incomes or are dependent on someone else's income.

Also identified in this study, is the role others who have been to treatment or who understand their own use/misuse can play in reducing shame and supporting their peers to access care. Such peer support initiatives should also be supported and consumers included in community-based training and action networks.

—☺ **Develop/enhance alcohol and drug treatment programming that serves mothers and children**

Programs and services that serve mothers and their children together are desperately needed. When women are able to bring their children

As women described in this study, issues of poverty, violence and depression are related to their substance use and their ability to access help.

to care, they should not have to fear losing their children solely on the basis of their substance use, nor should they have to go to great lengths to find childcare while they access help. Day treatment programs are most readily able to offer programming for both women and children, to address their separate needs and bring women and children together in common programming.

Existing women-only residential treatment and supportive living programs also need to examine their accessibility by pregnant and parenting women and work to help women find childcare that does not involve loss of custody. Other residential programs which currently serve women with their children on related issues (such as transition houses), also have a role in supporting women in accessing substance use treatment while maintaining custody and care of children.

—☺ **Ensure comprehensive care for women and their families**

As women described in this study, issues of poverty, violence and depression are related to their substance use and their ability to access help. Engaging women in care through services which are multidisciplinary and comprehensive may greatly enhance women's

connection to substance use care. Services such as the Sheway Project in the downtown eastside of Vancouver have been very successful in engaging pregnant women with substance use problems in accessing a range of supports – prenatal care, nutritional support, medical care, advocacy on housing and legal issues, support on custody and relationship issues, as well as alcohol and drug counselling – when provided in a caring, “one-stop” setting.

—☺ **Conduct research into successful strategies for engaging and retaining women in care**

Finally, it is recommended that planning, policy development and further studies be undertaken:

- That examine the impact of multiple, interconnected issues facing women – such as poverty, chronic physical health problems, experience of violence/trauma, mental health problems – and point to collaborative approaches that all services can adopt to provide supportive, holistic care
- That support the development and evaluation of a range of treatment options that are supportive of mothers with alcohol and other drug problems, and their families

Appendix 1

Interview Questions

(Note: Questionnaires used for pretreatment programs (with those entering pregnancy outreach or detoxification programs) were modified to be in the present tense.)

Question 1

Can you talk about what things (or people) made it hard for you to go to treatment? What were barriers for you?

Question 2

Do any of the following statements fit or hold true for you? Please feel free to add any comments you have.

- I felt I didn't really have a problem.
- I felt I could handle my problem myself.
- I was afraid of the way people would treat me because I'm pregnant/a mother and using.
- I was ashamed about having a problem with alcohol and drugs and having others know.
- I did not want my family to know.
- I felt too worthless or depressed to get it together to go.
- I was afraid I would lose my children if I said I needed treatment.
- I was afraid to go for treatment because the Ministry might find out.
- I didn't have anyone to watch/take care of my children while I was at treatment.
- My partner did not want me to get help.
- My partner actively tried to stop me from getting help (threatened me).
- Other family members did not want me to get help.

- Other family members actively tried to stop me from getting help (threatened me).
- I was not sure what treatment would be like.
- I didn't know what help was available.
- I felt I couldn't afford it financially.
- I had problems getting financial assistance.
- I felt I couldn't afford the time away from work or schooling.
- The cost of transportation to a treatment service was a problem for me.
- It was a long way to travel from where I was living, to treatment services.
- There was a waiting list for treatment services.
- The treatment service had too many requirements to meet before getting in.
- I have a pet and couldn't get anyone to take care of it while I got help.
- I was afraid of legal problems if I said I was using illegal drugs.
- The treatment program could not accommodate my disability/ special needs.
- I had bad experiences with getting help in the past.
- My doctor (or counsellor that I am seeing) did not seem to think that I needed help on alcohol and drug issues.
- My worker wanted me to go to a program that I didn't want to go to.
- I didn't think I could get help on alcohol and drug issues because I take prescribed medication or methadone.
- I thought I'd be out of place because of my age.

- I was afraid I wouldn't be understood and accepted because of my culture.
- I was afraid I wouldn't be understood and accepted because I'm a lesbian.
- I was afraid I wouldn't be understood and accepted because I'm HIV+.

Now that we have gone through this list of things, is there anything you would like to add about what were barriers for you?

Question 3

Can you talk about the things (or people) that helped you in deciding to go to treatment—what was supportive of you getting treatment?

Appendix 2

Tables on Responses to Structured Questions

Table 3: Responses to Structured Questions by Study Participants in Northern British Columbia

The Questions Asked		Pregnancy Outreach & Detox	Outpatient & Day Treatment	Residential Treatment & Supportive Recovery	Totals for Northern Services
1	I felt I didn't really have a problem	40%	80%	60%	60%
2	I felt I could handle my problem myself	50%	80%	80%	68%
3	I was afraid of the way people would treat me because I'm pregnant/a mother and using	50%	60%	40%	52%
4	I was ashamed about having a problem with alcohol and drugs and having others know	50%	70%	60%	60%
5	I did not want my family to know	10%	10%	0%	8%
6	I felt too worthless or depressed to get it together to go	50%	50%	80%	56%
7	I was afraid I would lose my children if I said I needed treatment	60%	60%	20%	52%
8	I was afraid to go for treatment because the Ministry might find out	40%	60%	20%	44%
9	I didn't have anyone to watch/take care of my children while I was at treatment	30%	60%	20%	40%
10	My partner did not want me to get help	40%	30%	60%	40%
11	My partner actively tried to stop me from getting help (threatened me)	10%	10%	20%	12%
12	Other family members did not want me to get help	10%	10%	0%	8%
13	Other family members actively tried to stop me from getting help (threatened me)	0%	0%	0%	0%
14	I was not sure what treatment would be like	60%	60%	80%	64%
15	I didn't know what help was available	30%	50%	80%	48%
16	I felt I couldn't afford it financially	50%	50%	40%	48%
17	I had problems getting financial assistance	10%	30%	40%	24%
18	I felt I couldn't afford the time away from work or schooling	20%	20%	0%	16%
19	The cost of transportation to a treatment service was a problem for me	0%	50%	40%	28%
20	It was a long way to travel from where I was living, to treatment services	30%	30%	40%	32%
21	There was a waiting list for treatment services	30%	20%	0%	20%
22	The treatment service had too many requirements to meet before getting in	20%	0%	20%	12%
23	I have a pet and couldn't get anyone to take care of it while I got help	0%	0%	0%	0%
24	I was afraid of legal problems if I said I was using illegal drugs	10%	20%	0%	12%
25	The treatment program could not accommodate my disability/special needs	0%	10%	20%	8%
26	I had bad experiences with getting help in the past	50%	20%	40%	36%
27	My doctor (or counsellor that I am seeing) did not seem to think that I needed help on alcohol and drug issues	20%	10%	0%	12%
28	My worker wanted me to go to a program that I didn't want to go to	20%	10%	20%	16%
29	I didn't think I could get help on alcohol and drug issues because I take prescribed medication or methadone	20%	10%	20%	16%
30	I thought I'd be out of place because of my age	30%	20%	20%	24%
31	I was afraid I wouldn't be understood and accepted because of my culture	20%	20%	20%	20%
32	I was afraid I wouldn't be understood and accepted because I'm a lesbian	0%	0%	0%	0%
33	I was afraid I wouldn't be understood and accepted because I'm HIV+	0%	0%	0%	0%
	Totals	N = 10	N = 10	N = 5	N = 25

Table 4: Responses to Structured Questions by Study Participants in Vancouver

The Questions Asked		Pregnancy Outreach & Detox	Outpatient & Day Treatment	Residential Treatment & Supportive Recovery	Totals for Southern Services
1	I felt I didn't really have a problem	80%	14%	0%	23%
2	I felt I could handle my problem myself	80%	43%	20%	41%
3	I was afraid of the way people would treat me because I'm pregnant/a mother and using	80%	43%	70%	64%
4	I was ashamed about having a problem with alcohol and drugs and having others know	40%	86%	80%	73%
5	I did not want my family to know	60%	57%	60%	59%
6	I felt too worthless or depressed to get it together to go	60%	43%	80%	64%
7	I was afraid I would lose my children if I said I needed treatment	100%	57%	70%	73%
8	I was afraid to go for treatment because the Ministry might find out	80%	14%	20%	32%
9	I didn't have anyone to watch/take care of my children while I was at treatment	40%	43%	20%	32%
10	My partner did not want me to get help	20%	14%	20%	18%
11	My partner actively tried to stop me from getting help (threatened me)	20%	14%	30%	23%
12	Other family members did not want me to get help	0%	0%	0%	0%
13	Other family members actively tried to stop me from getting help (threatened me)	20%	0%	10%	9%
14	I was not sure what treatment would be like	0%	29%	0%	9%
15	I didn't know what help was available	60%	57%	80%	68%
16	I felt I couldn't afford it financially	40%	43%	40%	41%
17	I had problems getting financial assistance	0%	43%	10%	18%
18	I felt I couldn't afford the time away from work or schooling	0%	14%	10%	9%
19	The cost of transportation to a treatment service was a problem for me	60%	29%	20%	32%
20	It was a long way to travel from where I was living, to treatment services	40%	57%	30%	41%
21	There was a waiting list for treatment services	80%	100%	90%	91%
22	The treatment service had too many requirements to meet before getting in	80%	0%	10%	23%
23	I have a pet and couldn't get anyone to take care of it while I got help	0%	0%	10%	5%
24	I was afraid of legal problems if I said I was using illegal drugs	40%	29%	20%	27%
25	The treatment program could not accommodate my disability/special needs	20%	0%	10%	9%
26	I had bad experiences with getting help in the past	60%	57%	40%	50%
27	My doctor (or counsellor that I am seeing) did not seem to think that I needed help on alcohol and drug issues	40%	0%	10%	14%
28	My worker wanted me to go to a program that I didn't want to go to	60%	29%	10%	27%
29	I didn't think I could get help on alcohol and drug issues because I take prescribed medication or methadone	0%	29%	0%	9%
30	I thought I'd be out of place because of my age	40%	0%	10%	14%
31	I was afraid I wouldn't be understood and accepted because of my culture	40%	14%	0%	14%
32	I was afraid I wouldn't be understood and accepted because I'm a lesbian	0%	0%	10%	5%
33	I was afraid I wouldn't be understood and accepted because I'm HIV+	20%	0%	0%	5%
	Totals	N = 5	N = 7	N = 10	N = 22

Table 5: Overview of All Responses to Structured Questions by Program Type and Location

The Questions Asked	Pregnancy Outreach & Detox	Outpatient & Day Treatment	Residential Treatment & Supportive Recovery	North	South	Total
I felt I didn't really have a problem	53%	55%	20%	60%	23%	43%
I felt I could handle my problem myself	60%	65%	40%	68%	41%	55%
I was afraid of the way people would treat me because I'm pregnant/a mother and using	60%	53%	60%	52%	64%	57%
I was ashamed about having a problem with alcohol and drugs and having others know	47%	76%	73%	60%	73%	66%
I did not want my family to know	27%	29%	40%	8%	59%	32%
I felt too worthless or depressed to get it together to go	53%	47%	80%	56%	64%	60%
I was afraid I would lose my children if I said I needed treatment	33%	53%	20%	52%	73%	62%
I was afraid to go for treatment because the Ministry might find out	33%	24%	33%	44%	32%	38%
I didn't have anyone to watch/take care of my children while I was at treatment	13%	12%	27%	40%	32%	36%
My partner did not want me to get help	33%	24%	33%	40%	18%	30%
My partner actively tried to stop me from getting help (threatened me)	13%	12%	27%	12%	23%	17%
Other family members did not want me to get help	7%	6%	0%	8%	0%	4%
Other family members actively tried to stop me from getting help (threatened me)	7%	0%	7%	0%	9%	4%
I was not sure what treatment would be like	40%	47%	27%	64%	9%	38%
I didn't know what help was available	40%	53%	80%	48%	68%	57%
I felt I couldn't afford it financially	47%	47%	40%	48%	41%	45%
I had problems getting financial assistance	7%	35%	20%	24%	18%	21%
I felt I couldn't afford the time away from work or schooling	13%	18%	7%	16%	9%	13%
The cost of transportation to a treatment service was a problem for me	20%	41%	27%	32%	32%	30%
It was a long way to travel from where I was living, to treatment services	33%	41%	33%	32%	41%	36%
There was a waiting list for treatment services	47%	53%	60%	20%	91%	53%
The treatment service had too many requirements to meet before getting in	40%	0%	13%	12%	23%	17%
I have a pet and couldn't get anyone to take care of it while I got help	0%	0%	7%	0%	5%	2%
I was afraid of legal problems if I said I was using illegal drugs	20%	24%	13%	12%	27%	19%
The treatment program could not accommodate my disability/special needs	7%	6%	13%	8%	9%	9%
I had bad experiences with getting help in the past	53%	35%	40%	36%	50%	43%
My doctor (or counsellor that I am seeing) did not seem to think that I needed help on alcohol and drug issues	27%	6%	7%	12%	14%	13%
My worker wanted me to go to a program that I didn't want to go to	33%	18%	13%	16%	27%	21%
I didn't think I could get help on alcohol and drug issues because I take prescribed medication or methadone	13%	18%	7%	16%	9%	13%
I thought I'd be out of place because of my age	33%	12%	13%	24%	14%	19%
I was afraid I wouldn't be understood and accepted because of my culture	27%	18%	7%	20%	14%	17%
I was afraid I wouldn't be understood and accepted because I'm a lesbian	0%	0%	7%	0%	5%	2%
I was afraid I wouldn't be understood and accepted because I'm HIV+	7%	0%	0%	0%	5%	2%
Totals	N = 15	N = 17	N = 15	N = 25	N = 22	N = 47

Appendix 3

Research Summary, Published as Part of “Mothering and Substance Use: A Women-Centred Policy Perspective” Information Package

This research was conducted with 47 women in British Columbia (in Vancouver and Prince George) who were pregnant and/or parenting children under age 16 and were present for help for alcohol and other drug problems. The research took place between February and May 1998, when study participants were beginning to access one of the following levels of care: detoxification services; pregnancy outreach programs; outpatient counselling sessions; day treatment programs; residential treatment programs; or supportive recovery home services.

How women described their lives and how they arrived at addictions services, often after years of guilt and denial, underlines the importance of recognizing women’s distinct needs as mothers when addressing their substance use problems.

Barriers Cited

Women who are parenting and who have substance use problems come face to face with society’s negative attitudes about them. In describing living with addictions and their experiences in seeking help, women identified feelings of shame, guilt and fear as primary obstacles in getting help.

Using structured questions, study participants identified the following barriers to accessing treatment, in order of frequency:

- shame
- fear of losing children if they identified as needing treatment
- fear of encountering prejudice because of being mothers and/or pregnant and having substance use problems
- feelings of depression and low self-esteem

- believing they could handle the problem without treatment
- lack of information about what treatment was available
- waiting lists for treatment services

Through open-ended questions, study participants spoke of the primary causes of delay in seeking or getting help for substance misuse as linked to their sense of self and their status as caregivers. Lack of childcare, fear of losing custody, unwillingness to leave their children in the care of others and being actively discouraged from entering treatment by partners (in ways ranging from subtly coercive threats and criticisms to overt violence) were major barriers.

The timing of a woman's decision to access addictions programs is strongly linked to the suspension of daily responsibility for children, whether voluntarily or involuntarily. Expanding childcare options so that recovery is motivated by a desire to make positive changes, rather than by coercion, is therefore of utmost importance.

A further challenge is to increase awareness of alcohol and drug treatment services so that women know about the range of services that allow them to get care without giving up their children. It is also critical that service providers wel-

come women who are parents and/or pregnant, and that services directly address feelings of guilt, shame and fear.

Supports Cited

In response to an open-ended question about what was supportive of their accessing treatment, women identified five key factors, in order of frequency:

- support provided by a wide range of professionals
- supportive family members
- supportive friends and people encountered in the recovery movement
- motivation to get help on account of children
- the alcohol and drug system of care working optimally (the type of care they needed being available, specialized programming for women being available, referrals made between levels of care so that women successfully got to the type of care they needed, etc.)

While women stressed that fear and shame led them to hide their problems, even from themselves, their experience with accessing services affirms that barriers can be overcome when personal readiness and hope are met with non-judgmental referrals and information that recognizes their distinct needs as mothers.

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Appréhensions

Obstacles au traitement des mères toxicomanes

Ce rapport de recherche sur la santé des femmes est offert en français et sous des formes utilisables par les personnes handicapées. Pour plus de détails, veuillez communiquer avec le Centre d'excellence de la C.-B. pour la santé des femmes

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