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ACCEPTANCE

This dissertation, AFRICAN AMERICAN WOMEN'S PERCEPTIONS OF AND EXPERIENCES WITH MANDATED SUBSTANCE ABUSE TREATMENT: IMPLICATIONS FOR COUNSELORS, by KATHRYN NEWTON, was prepared under the direction of the candidate's Dissertation Advisory Committee. It is accepted by the committee members in partial fulfillment of the requirements for the degree Doctor of Philosophy in the College of Education, Georgia State University.

The Dissertation Advisory Committee and the student's Department Chair, as representatives of the faculty, certify that this dissertation has met all standards of excellence and scholarship as determined by the faculty. The Dean of the College of Education concurs.

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Kathryn Newton

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ABSTRACT

AFRICAN AMERICAN WOMEN'S PERCEPTIONS OF AND EXPERIENCES WITH MANDATED SUBSTANCE ABUSE TREATMENT: IMPLICATIONS FOR COUNSELORS

by

Kathryn Newton

African American women, in particular those who are economically marginalized, are disproportionately subject to surveillance by social service and criminal justice agencies (James et al., 2003) and are vulnerable to race- and gender-biased policy implementation (Chibnall et al., 2003; Zerai, 2002). They also experience population-specific personal (Ehrmin, 2001, 2002), social (Riehman, Iguchi, Zeller, & Morral, 2003; MacMaster, 2005), and economic barriers (Tighe & Saxe, 2006) to accessing and entering substance abuse treatment services. These factors contribute to lower rates of treatment entry follow-through (Siqueland et al., 2002) and higher drop-out rates (Scott-Lennox, Rose, Bohlig, & Lennox, 2000) than women from other racial and ethnic groups. This qualitative study explored African American women's perceptions of mandated referral to substance abuse treatment and the impact of those perceptions on their treatment entry. The sample included 17 women age 18 years and over who were currently enrolled at three gender-specific treatment programs (one intensive outpatient and two residential) in a major southeastern urban area. This naturalistic inquiry (Lincoln and Guba, 1987) was informed by Black feminist epistemology (Collins, 2000) in accordance with recommendations for culturally sensitive research with women of color

(Landrine, Klonoff, & Brown-Collins, 1995). Participants completed one-time, in-depth (one to two hour) interviews in which they were invited to explore their experiences with mandated substance abuse treatment referrals from state agencies (child protective services and the criminal justice system). Results indicate that participants generally perceived the treatment mandate as helpful. However, they also indicated that their willingness and ability to follow-through with treatment entry were influenced by multidimensional (Marlowe, Merikle, Kirby, Festinger, & McLellan, 2001) and interacting factors. Participants identified influence factors that included intra- and interpersonal concerns, the quality of interactions with state agencies, and treatment-specific issues. Results are presented along with suggestions for counselors and future research.

AFRICAN AMERICAN WOMEN'S PERCEPTIONS OF AND EXPERIENCES WITH MANDATED SUBSTANCE ABUSE TREATMENT: IMPLICATIONS FOR COUNSELORS

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A Dissertation

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ABBREVIATIONS

CJS	Criminal Justice System
CPS	Child Protective Services
PI	Primary Investigator
SES	Socioeconomic Status
TANF	Temporary Aid to Needy Families

CHAPTER 1

AFRICAN AMERICAN WOMEN AND MANDATED SUBSTANCE ABUSE TREATMENT

African American women experience significant individual, relational, and socioeconomic stressors. Compared to women of other racial/ethnic groups they are far more likely to be single parents, to live in impoverished communities, and to have lower overall rates of educational attainment (DeNavas-Walt, Proctor, & Lee, 2006). African American women also experience high rates of childhood sexual abuse, intimate partner abuse, and exposure to community violence (Amaro et al., 2005; West, 2002). Exposure to abuse and violence among African American women has been positively correlated with substance abuse (James et al., 2003; Martin et al., 2005; Miller & Flaherty, 2000; Zule, Flannery, Wechsberg, & Lam, 2002). Among poor African American women, these same factors contribute to increased interaction with and surveillance by social services and the criminal justice system (James et al., 2003).

Because African American women are more likely to be monitored by state authorities and agencies (James et al., 2003; Coyle, n.d.), they are more likely to be identified as using illicit substances, and thus more likely to be mandated to treatment under threat of state sanctions. Typical sanctions used to leverage treatment compliance include loss of custody of minor children; reduced access to welfare benefits and employment assistance; and more severe probation, parole, and prison terms. While

substance abuse treatment is indicated in many cases, the nature of the sanctions may be experienced by African American women as yet another threat to the safety and stability of themselves and their families (Azzi-Lessing & Olsen, 1996; Burman, 2004).

There is growing acknowledgement of the role of culture-specific issues in substance abuse treatment (Straussner, 2001), however the concerns and needs of African American women remain marginalized in substance abuse literature (Constantine, 2006; McAdoo, 2002; Roberts, Jackson, & Carlton-LaNey, 2000; Wright, 2001). This deficit in understanding is problematic given the interplay of issues related to gender (Lewis, 2004; West, 2002), race/ethnicity (Boyd, Phillips, & Dorsey, 2003; Turner & Wallace, 2003), culture (Ehrmin, 2005; Lewis, 2004), and socioeconomic status (SES; Hayes & Way, 2003; Heflin, Siefert, & Williams, 2005; Miller & Neaigus, 2002) that are often experienced by African American women entering treatment through mandated referrals. The purpose of this article is to provide an overview of empirical, conceptual, and theoretical literature pertaining specifically to African American women and substance abuse, substance abuse treatment, system intervention, and mandated treatment. The review will conclude with recommendations for treatment programs, substance abuse counselors, and researchers.

African American Women and Substance Abuse

The 2006 National Survey on Drug Use and Health (Substance Abuse and Mental Health Services Administration [SAMHSA], 2007) estimated that 8.1% of the population 18 years and older engaged in past-month illicit drug use; rates were slightly higher among Blacks (9.7%) than among Whites (8.4%) and Hispanics (6.6%). By gender,

Black females (8.7%) reported slightly higher past-month use of illicit drug use than White (8.3%) or Hispanic (8%) females. The same survey estimated that 9.2% of the population age 12 years and older could be classified with past-year substance dependence or abuse. Rates were slightly lower among African Americans (9%) than that among Whites (9.2%) and Hispanics (10.0%). The rate of past-year substance abuse or dependence for African American females (4.5%) age 18 years and over was found to be lower than that for Whites (6.3%) but higher than that for Hispanic (4.4%) and Asian females (3.4%; SAMHSA, 2005).

Women with co-occurring mental health and substance abuse disorders (Amaro et al., 2005) and women accessing behavioral health services in the southeast (Jerrell, Wieduwilt, & Macey, 2002) were found to have no significant differences in overall substance abuse by race or ethnicity. There are, however, consistent indications of gender and racial/ethnic group differences in use rates for crack cocaine. Nationwide, this is the single illicit substance for which African American women entering treatment report rates similar to African American men and significantly higher than women from other racial and ethnic groups (SAMHSA, 2006a).

It is possible that overall alcohol and other drug use by African American women is underreported, particularly among poor and low-income women who are most vulnerable to state intervention (Kip, Peters, & Morrison-Rodriguez, 2002; Metsch & Pollack, 2005). Studies have found that accurate self-reporting was compromised by African American women's fears of being stigmatized within their families and communities (Ehrmin, 2001) or of losing access to critical benefits and services (Metsch

& Pollack, 2005). Epidemiological surveys that fail to include incarcerated populations, where African American women are currently overrepresented, may contribute to underreporting (Bogart, Stevens, Hill, & Estrada, 2005; Henriques & Manatu-Rupert, 2001; Kip et al., 2002).

African American women and cocaine use. African American women are at greater risk than females of any other racial or ethnic group for initiating use and becoming dependent on crack cocaine (Bernstein et al., 2006; SAMHSA, 2006b). African American women accounted for a majority of cocaine treatment admits in 12 of 14 major metropolitan areas (Community Epidemiology Working Group, 2006). Among African American women admitted to public treatment, smoked cocaine (crack) is the most common primary substance of abuse (30%), followed by heroin (17%), alcohol in combination with a drug (16%), and marijuana (15%; SAMHSA, 2006a). The same study reported that crack cocaine was the primary drug of choice for 20% of African American males, 8% of White females, and 6 to 10% of Latinas. Use patterns among African American women varied by age: the primary substance of abuse reported by those under age 25 was marijuana whereas for those 25 and older it was cocaine and heroin.

Predictors of Substance Abuse

Predictors of substance abuse among African American women include SES, exposure to violence, and family and social factors. Substance use among African American women can be found across socioeconomic levels, however poor and low-income women are at greatest risk for substance use escalating to abuse and dependency (Blank, 2001; James et al., 2003; Staples, 1990). Among women who abuse substances,

African American females are likely to have significantly lower levels of educational attainment and higher rates of poverty and unemployment than White females (Amaro et al., 2005; Boyd et al., 2003; West, 2002). Being on welfare for five or more years has been positively correlated with past-year cocaine and marijuana use; poor African American women who also were substance abusing or dependent were more likely to evidence persistent welfare dependency (Williams, Juon, & Ensminger, 2004).

Poverty also has been correlated with reliance on intimate partners and sex trade for access to economic resources and drugs, further compounding substance abuse risk factors (Miller & Neaigus, 2002; West, 2002). Drug-involved intimate partners often contribute to women's substance use initiation and escalation (Riehman, Hser, & Zeller, 2000). Conversely, employment rates among substance-abusing African American women have been negatively correlated with drug use and stress (Atkinson, Montoya, Whitsett, Bell, & Nagy, 2003).

Having a history of repeated childhood sexual abuse (Morrison, DiClemente, Wingood, & Collins, 1998; West, 2002) and feeling abandoned by parents to sexual abuse (Dunlap, Sturzenhofecker, Sanabria, & Johnson, 2004; Wright, 2003) are both predictors of substance abuse for African American women. Duration and severity of childhood sexual abuse also have been correlated with age of onset and severity of substance abuse symptoms and with addiction to multiple substances (Boyd, Guthrie, Pohl, & Whitmarsh, 1994; Young & Boyd, 2000). Furthermore, maternal drug and alcohol use has been found to predict exposure to childhood sexual abuse of children (Morrison et al.) and intergenerational transfer of violent behavior (Dunlap et al., 2004).

Intimate partner violence also puts African American women at risk for substance abuse (Curtis-Boles & Jenkins-Monroe, 2000). Nearly a quarter of African American women have reported being victims of intimate partner violence (West, 2002). African American women in the lowest socioeconomic brackets experience the highest rates of intimate partner violence, with the most severe injuries (James et al.; Josephson, 2005).

Individual risk for substance abuse among African American women has been linked to family and social factors. African American females who have male family members who abuse substances evidence higher rates of substance abuse (Morrison et al., 1998). A within-group study of urban and low-income African American women associated lack of family support during adolescence and disconnection from church-based community with increased incidence of substance abuse (Curtis-Boles & Jenkins-Monroe, 2000).

Consequences of Substance Abuse

African American women in both urban and rural locations have been found to experience more numerous and more severe consequences of substance abuse than White women (Beatty, 2003; Bernstein et al., 2006; Boyd et al., 2003; Constantine, 2006)

Among African Americans, health concerns exacerbated by substance abuse, especially abuse of cocaine, include injury, hypertension, and cardiac conditions (Bernstein et al., 2006) and substance use contributes to more health problems among women than men (Brunswick & Messeri, 1999). Among African American women, heavy drinking has been associated with increased use of crack cocaine, prevalence of sexual risk behaviors, and increased risk for sexually transmitted diseases and HIV

infection (Zule et al., 2002). Substance-abusing African American women, particularly those living in poverty, are at significant risk for contracting HIV/AIDS and account for the majority (64%) of all female cases of HIV/AIDS infection – a rate over three times greater than that for White females (Centers for Disease Control and Prevention, 2007). Among African American women aged 25 to 34, AIDS is the leading cause of death. Substance-abusing African American women are most at risk for co-occurring mental health consequences when faced with multiple stressors. The overall rate of suicide among African Americans is lower than that for Whites, and lower still among African American women, however identified risk factors include substance abuse, depression, family dysfunction and violence, and positive HIV/AIDS status (Gibbs, 1997) as well as negative self-image (Friedman, Terras, Zhu, & McCallum, 2004).

Within-group studies have linked substance abuse among African American women with ineffective emotional coping (Ehrmin, 2002; Miller & Neaigus, 2002; Roberts, 1999), feelings of guilt and shame (Ehrmin, 2001), and the internalizing of racism and familial abuse (Constantine, 2006; Curtis-Boles & Jenkins-Monroe). African American women are at risk for being dually diagnosed with post-traumatic stress disorder (Montoya, Covarrubias, Patek, & Graves, 2003) and those who drink heavily have experienced greater distress related to co-morbid mental health issues (Zule et al., 2002). Compared to African American males, females have been found to engage in less substance use, but evidence higher rates of substance-related depression (Wang, Collins, DiClemente, Wingood, & Kohler, 2001).

Collectively, the available literature on predictors for and consequences of substance abuse in African American women suggests a complex interplay of individual, relational, sociocultural, and economic factors. These factors are evident in African American women's experiences with substance abuse treatment.

African American Women and Substance Abuse Treatment

In a recent survey of public treatment admissions, women accounted for just over 30% of all admissions to public substance abuse treatment programs; of these 7% were African American women (SAMHSA, 2006a) a number roughly proportionate with their representation in the overall population. The same study found that White females accounted for 20% of all admissions, and African American males represented 16% of admissions. The following section outlines issues for African American women with accessing services, as well as with treatment entry, retention, and outcomes.

Access to Treatment Services

Living in high-poverty areas has been directly correlated with higher incidence of mental health distress in women (Heflin et al., 2005; Leventhal & Brooks-Gunn, 2003; Myers & Gill, 2004) and greater difficulty accessing mental health services (Chow, Jaffee, & Snowden, 2003). The 2005 national poverty rate for African Americans was 25%, a rate that is twice the representation in the overall population (13%) and three times the poverty rate of non-Hispanic whites (8%; DeNavas-Walt et al., 2006). Among African American women, 30% of single adult females and 40% of families headed by single females are living below the federal poverty line, a 10% higher poverty rate than that for non-Hispanic white females (United States Census Bureau, 2006). While the

implementation of managed care appears to have improved access to and quality of care for African Americans, it has not altered racial disparities in health care (Daley, 2005; Wells, Klap, Koike, & Sherbourne, 2001). A recent report based on census data from 2005 indicated that 20% of African Americans, compared to 11% of non-Hispanic whites, were without health insurance coverage (DeNavas-Walt et al.).

Among low-income women with self-identified health and substance abuse problems, one in four reported that fear of punitive repercussions (i.e. challenges to child custody or welfare benefits) prevented them from seeking services (Rosen, Tolman, & Warner, 2004). A similar proportion did not get care due to cost and lack of insurance. Even after efforts to improve substance abuse treatment utilization in high-risk communities, evaluative results found that although African American women were less likely to need services, they also were less likely to receive services when needed (Tighe & Saxe, 2006). Tighe and Saxe also found that women in impoverished communities were seven times less likely than men, and African American community members were four times less likely than Whites, to receive needed services.

Treatment Entry

Factors found to influence substance abuse treatment entry for African American women include parenting status, access to resources, motivation, and treatment expectations. The number of treatment facilities offering programs or groups tailored to the needs of women has increased. However, there are still few options for pregnant or postpartum women and only 18% of facilities with special programs for women offer childcare services (SAMHSA, 2006c). These limitations in services contribute to drop-

out rates among women of child-bearing age, with some of the highest treatment drop-out rates found in pregnant and-or parenting African American women (Scott-Lennox, Rose, Bohlig, & Lennox, 2000). African American women may fear losing custody of children if they seek help for substance abuse problems (Allen, 1995; Brady & Ashley, 2005) and also may be concerned about treatment conflicting with family responsibilities (Allen; Wyatt, Carmona, Loeb, & Williams, 2005).

While practical barriers such as childcare, transportation, and fees are important to consider, substance-abusing African American women have reported that feelings of shame, guilt, and hopelessness are more salient obstacles to seeking and entering treatment (Ehrmin, 2001; Roberts & Nishimoto, 2006; Turner & Wallace, 2003). Those who use substances as a means of numbing emotional pain report fear of relinquishing their coping mechanism (Allen, 1995; Ehrmin, 2002; Roberts, 1999). African American women also have reported fear of directly addressing the suffering their substance use has inflicted on loved ones, especially dependent children (Allen; Ehrmin, 2001).

Finally, relational factors create additional barriers to treatment entry. Substance-abusing African American women have described feelings of isolation and lack of social support that led to attachment to drug-involved peer networks (Roberts, 1999). African American women who have had negative experiences with social service professionals and state authorities, were found to have similar negative expectations of treatment staff (Roberts). Having friends and drug-involved intimate partners who disapprove of treatment may prevent women from following through on help-seeking behavior (Brady & Ashley, 2005; Riehman, Iguchi, Zeller, & Morral, 2003; Roberts & Nishimoto, 2006).

Treatment Retention and Outcomes

Factors that affect treatment retention and completion for African American women include individual readiness, the availability of integrated services, and culture- and gender-specific concerns. Treatment readiness plays an important role in both short- and long-term retention for this population (Dakof et al., 2003). In a study of actively using African American women just over half (56%) had no prior treatment; however the majority (84%) described themselves as having a high personal need for treatment (Roberts & Nishimoto, 2006). Among the most pressing concerns identified for African American women in treatment are parenting status (Lewis, 2004; Roberts & Nishimoto), employment and financial stressors (Atkinson et al., 2003), and the use of culturally-appropriate interventions (Lewis). Other help-seeking concerns include domestic violence (Brown, Melchior, Panter, Slaughter, & Huba, 2000; Gatz et al., 2005), co-occurring mental heath disorders (SAMHSA, 2004), and post-traumatic stress symptoms (Montoya, Covarrubias, Patek, & Graves, 2003; Roberts, 1999).

Integrated services. There is a growing consensus regarding the need for integrated treatment services for women in general, particularly the integration of mental health, substance abuse, and trauma services (Gatz et al., 2005; Powis, Gossop, Bury, Payne, & Griffiths, 2000; Young & Boyd, 2000). Although these services are critical for the majority of women in treatment, African American women may perceive economic support services as a primary need. Studies have found that African American women seeking treatment are often burdened by deficits in basic resources such as food, housing, employment, and transportation (Azzi-Lessing & Olsen, 1996; Rosen et al., 2004).

Of treatment facilities nationwide, over half (55%) provide assistance with obtaining social services, 43% provide housing assistance, 37% help with employment needs, and approximately one-third (30%) offer transportation to treatment (SAMHSA, 2004). Under-resourced African American women have been retained longer in treatment programs that provide vocational training (Atkinson et al., 2003; Howell, Heiser, & Harrington, 1999) and have benefited from programs that conducted more thorough needs assessments and assisted with matching services (Amaro et al., 2005; McAlpine, Marshall, & Doran, 2001).

Culture- and gender-specific concerns. Howard (2003) outlined characteristics common to culturally competent treatment programs serving African American clients. These programs tended to be federally funded and were more likely to have supervisors and staff who were African American, college educated, who had certification in substance abuse counseling, and experience working in treatment (Howard). African American clients have reported increased satisfaction with programs that integrate race and culture-specific images, languages, and parenting styles (Aktan, 1999; Lewis, 2004). Furthermore, African Americans in recovery have identified race and culture barriers in Twelve-Step philosophy and implementation (Durant, 2005; Sanders, 2002).

Culturally-relevant considerations for African American women in substance abuse treatment include attention to sociocultural and political contexts, internalized negative stereotypes, spirituality, and safety (Lewis, 2004). Among substance abusing African American women in recovery, those with high spirituality were found to have improved self-concept, increased active coping, more positive perception of family

climate, and increased satisfaction with social support (Brome, Owens, Allen, & Vevaina, 2000). Roberts et al. (2000) recommended that Black feminist theory be used as a foundation for treatment interventions with this population.

Women in general have evidenced improved treatment outcomes when they are allowed to have a voice in their treatment and recovery planning (SAMHSA, 2004). Among female African American abusers of crack cocaine, a woman-focused intervention was found to be more effective than standard treatment for reducing high-risk behavior and improving employment rates (Wechsberg, Lam, Zule, & Bobashev, 2004). African American women in treatment have expressed a need for receiving guidance and direction from treatment staff, developing reciprocal support with other women in recovery, and having the opportunity to resolve painful feelings and experiences (Dakof et al., 2003; Ehrmin, 2002, 2005; Stahler et al., 2005). They have also expressed a need for treatment staff to instill hopefulness (Roberts & Nishimoto, 2006) and support them with finding meaning and purpose in their experiences with substance abuse (Ehrmin, 2002; Wright, 2003). Furthermore, they reported a preference for treatment staff who were non-judgmental, forgiving, and who demonstrated unconditional positive regard (Dakof et al., 2003; Ehrmin, 2001; Roberts, 1999). One study found that linking women with church-associated female mentors improved retention, abstinence rates, and overall client satisfaction with treatment (Stahler et al., 2005).

African American women's parenting status also has been found to influence treatment retention. Retention rates for parenting African American women were found

to be higher at programs that provide integrated support services (Finkelstein, 1994; Lewis, 2004; Marsh, D'Aunno, & Smith, 2000) and parenting classes (Howell et al., 1999). They also were found to benefit from programs that integrated child welfare issues with treatment (McAlpine et al., 2001). Furthermore, African American women whose children were in foster care at time of treatment had higher retention rates than those with primary custody of minor children (Scott-Lennox et al., 2000).

There is no question that African American women, especially those who are poor, face significant barriers to accessing treatment. It is evident that they experience unique cultural and gender treatment needs, that many of these needs are unique to the intersection of gender and race, and that there are within-group differences that require special consideration. One such consideration is the use of mandated treatment and the impact of state sanctions on treatment efficacy. Literature pertaining to mandated treatment in general and the efficacy of this approach with African American women is covered in the following section.

Mandated Substance Abuse Treatment

The descriptors *mandated*, *coerced*, *involuntary*, and *compulsory* have been used interchangeably in substance abuse treatment literature to indicate the use of external sanctions as compliance motivators, most commonly in the context of criminal justice system referrals (Farabee, Prendergast, & Anglin, 1998; Polcin & Greenfield, 2003). Individuals may be subject to external sanctions from a variety of sources including pressure from family, friends, employers, medical professionals, the criminal justice system, and social service agencies (Farabee et al.; Klag, O'Callaghan, & Creed,

2005). For the purpose of this literature review, the term *mandated* has been used to indicate the use of state-imposed sanctions unless otherwise specified. State-imposed sanctions originate in the criminal justice and social welfare systems, including child protective services. A recent national survey of treatment admissions found that the criminal justice system and self-referral each accounted for over one-third (36% and 34% respectively) of all referrals to public treatment facilities (SAMHSA, 2006a). Medical and mental health professionals together comprised 18% of referrals and 10% were from other social and community services.

The efficacy of mandated substance abuse treatment appears to be influenced by the interaction between multiple sources of pressure including external sanctions, individual perceptions of pressure (Marlowe, Merikle, Kirby, Festinger, & McLellan, 2001; Maxwell, 2000), and individual motivation (Berg & Shafer, 2004; DiClemente, 2003). Other factors that have been found to influence the efficacy of mandated treatment include age and gender (Gregoire & Burke, 2003; Kelly, Finney, & Moos, 2005) and severity of substance use (Rapp, Siegal, & DeLiberty, 2003). Legal coercion has been positively correlated with readiness for change, particularly among women (Gregoire & Burke), however there may be no significant relationship between early motivation and post-treatment outcomes (Rapp et al.).

Mandated clients who were asked to rank treatment entry motivators made significant distinctions between source and context of pressure (Marlowe et al., 1996; Marlowe et al., 2001; Young, 2002) and have ranked legal pressure significantly lower than psychological, financial, and social/family sources of pressure (Marlowe et al.,

1996). In summarizing three decades of literature on mandated treatment, Klag et al. (2005) noted that, "people's attitudes and perceptions may exert a greater impact on why they enter, stay, and succeed in treatment than their objective legal status" (p. 1785). Therefore, the role of individual attitudes and perceptions are of particular concern in the use of mandated treatment with African American women.

African American Women and Mandated Treatment Referrals

Changes to welfare (Metsch & Pollack, 2005) and drug sentencing (Coyle, n.d.; United States Sentencing Commission, 2007) policies over the past decade have contributed to increased social surveillance and criminalization of the poor and people of color (James et al.). One outcome of this "hyper surveillance" (James et al.) is steadily rising rates of state-mandated treatment referrals and incarceration among African American women (Bogart et al., 2005; Burke). The most frequent sources of mandated treatment referrals for African American women are welfare services (Metsch & Pollack, 2005), child protective services (Azzi-Lessing & Olsen, 1996; Brecht, Anglin, & Dylan, 2005), and the criminal justice system (Bogart et al.; Zerai, 2002). African American women's involvement with each system and reasons for mandated referrals are addressed in the following section.

Social welfare referrals. One in four African American women live below the poverty line with even higher rates among single mothers of dependent children (United States Census Bureau, 2006). These statistics are reflected in data from Temporary Aid to Needy Families (TANF): 39% of adult TANF recipients are African American, a rate three times the representation in the general population. (Administration for Children &

Families, 2006). In the social welfare system, changes in federal policy have put pressure on states to reduce the number of welfare recipients and also have given states the freedom to administer sanctions of their choosing (Metsch & Pollack, 2005). Accordingly, many states have implemented mandatory alcohol and drug screenings for individuals seeking assistance through welfare and ready-to-work programs (Brady & Ashley, 2005).

Women who are identified as having substance abuse problems may not receive appropriate referrals from local welfare offices that may not have the resources, nor the trained staff, to adequately assess substance abuse severity (Azzi-Lessing & Olsen, 1996; Metsch & Pollack, 2005). Underlying trauma and mental health issues are frequently undetected resulting in inappropriate referrals and, in the case of noncompliance, a loss of access to critical resources for women and their dependent children (Burke, 2002; Metsch & Pollack). Changes in federal welfare policy have restricted access to disability benefits for adults with substance abuse diagnoses (Metsch & Pollack). Given this climate, it is not surprising that African American women receiving TANF benefits have been found to underreport their substance use (Metsch & Pollack).

Child protective services referrals. Child protective services (CPS) records have indicated that up to 80% of child welfare reports may be related to parental/guardian substance abuse, and that parental substance abuse is one of the primary reasons for children entering state care (Azzi-Lessing & Olsen, 1996; McAlpine et al., 2001; Metsch & Pollack, 2005). Women who have or who are seeking child visitation and/or custody often must comply with a series of judicial mandates that can include alcohol and drug

screenings, substance abuse treatment, parenting classes, vocational or educational training, and employment requirements (Rittner & Dozier, 2000). African American women with CPS cases and mandated treatment referrals who have difficulty complying are at risk for restriction or loss of welfare benefits (Metsch & Pollack), termination of parental right (Azzi-Lessing & Olsen), and incarceration (Zerai, 2002). Child welfare workers have attributed discriminatory child welfare reporting and enforcement to poverty-related risk factors, cultural parenting differences, economic and political disempowerment of the African American community, and racial stereotyping in media reports and among child welfare workers (Chibnall et al., 2003).

Criminal justice system referrals. Poverty and race have been identified as predictors of mandated substance abuse treatment referrals from the criminal justice system (CJS). Kansal (2005) concluded that African American defendants (as compared to Whites) were disadvantaged in legal processes and resources and received harsher sentences for less severe crimes (such as minor drug possession and distribution charges). African Americans in both low and high poverty areas have been found to have higher rates of state-mandated mental health referrals including to substance abuse treatment (Chow et al., 2003; Gregoire & Burke, 2003).

Nationwide, African American women have comprised the majority of females incarcerated for drug-related offenses (Henriques & Manatu-Rupert, 2001; Zerai, 2002). United States Department of Justice incarceration statistics (Harrison & Beck, 2003) indicated that drug offenses between 1995 and 2001 accounted for 15% of the growth in the overall offender population, and 13% of the growth among female offenders. By race,

drug offenses accounted for 23% of the growth among African American inmates and 18% among White inmates. Adult African American females of all ages were five times as likely as White females, and twice as likely as Hispanic females, to be incarcerated. Researchers have provided survey data indicating that the majority of imprisoned African American women come from impoverished backgrounds, have low educational attainment, and report high rates of childhood sexual abuse (Burke, 2002; Henriques & Manatu-Rupert).

The overrepresentation of African American women in the CJS has been attributed, at least in part, to unjust federal drug sentencing polices combined with disproportionate rates of crack cocaine use in this population (Coyle, n. d.; Kansal, 2005). When crack cocaine emerged on the drug market in the mid-1980's fears about crack-associated violence, addictiveness, and harm to neonates and newborns led to severe sentencing penalties for possession, distribution, and use (Kansal; United States Sentencing Commission, 2007). Sentencing guidelines and policy implementation disproportionately targeted African American communities (Coyle; Kansal; The Sentencing Project).

The 2007 United States Sentencing Commission's report on cocaine sentencing policy stated that 81.8% of defendants with crack cocaine charges were African American, a fact that the commission attributed to unsubstantiated risks and overly severe penalties for first-time and minor offenders. After two decades of debate and four empirically-based congressional reports recommending policy revision, the inequities in

drug sentencing have only recently begun to be addressed by the legislature in proposed policy revisions (United States Sentencing Commission).

African American women who abuse or become dependent on crack cocaine and who are economically marginalized are at significant risk for engaging in prostitution as a means of securing basic resources and drugs (Miller & Neaigus, 2002). While it is clear that poor African American women are disproportionately subject to substance abuse risk factors and mandated treatment referrals, less is known about the efficacy and outcomes of these referrals for this population. In the following section, literature specific to mandated treatment outcomes for African American women will be reviewed.

African American Women and Mandated Substance Abuse Treatment

The majority of available research on mandated treatment is based on samples from offender populations that are primarily male and White or are of mixed race and gender (Bouffard & Taxman, 2004; Gregoire & Burke, 2003; Kelly et al., 2005; Marlowe et al., 1996). One such large-scale study (Siqueland et al., 2002) identified variables predicting drop-out during the treatment intake period. Those variables included being African American, unemployed, young adult, and/or reporting higher rates of cocaine use.

A small but growing number of researchers have begun to examine unique issues for women mandated to substance abuse treatment. Studies that have included or focused on African American women suggest that individual variables interact with gender, race/ethnicity, and socioeconomic status to influence treatment entry and outcomes. African American women with CPS treatment mandates ranked personal and program-

related barriers significantly higher than logistical concerns (e. g. childcare, transportation, work; Roberts & Nishimoto, 2006). Other reported barriers to treatment entry included fear, housing instability, not wanting treatment (MacMaster, 2005); and feeling forced into treatment (Lewis, 2004).

Barriers to treatment completion that have been reported by African American women with mandated referrals were substance abuse severity, poor motivation, staff attitudes, dissatisfaction with program structure or services, and friends who did not support treatment participation (Roberts & Nishimoto, 2006). Marsh et al. (2000) found that integrating social services such as transportation, outreach, and child care improved both access to treatment and treatment outcomes.

Among African American women, coercion via control of parental rights has been found to initially motivate treatment compliance (Ehrmin, 2001). Nevertheless, Scott-Lennox et al. (2000) found that African American women who were younger, had custody of young children, or who were pregnant were more likely to drop out of treatment, while women with children in foster care were more likely to complete. Rittner and Dozier (2000) completed an analysis of court-involved CPS cases and determined that mandated treatment compliance declined significantly over time for all guardians.

There are indications that culture and gender-specific treatment approaches have contributed to improved outcomes for this population (Rounds-Bryant, Motivans, & Pelissier, 2003). Culturally appropriate interventions have been found to improve treatment entry (Dakof et al., 2003) and retention rates (Beckerman & Fontana, 2001) as well as post-treatment abstinence and involvement in employment and job training

(Uziel-Miller, Lyons, Kissel, & Love, 1998). Literature-based recommendations for treatment programs, substance abuse counselors, and researchers are discussed in the concluding section.

Summary and Recommendations

Studies addressing substance abuse in African American women have explored physical (Bernstein et al., 2006; Constantine, 2006) and mental health (Constantine, 2006; Zule et al., 2002) consequences, within-group risk factors (Curtis-Boles & Jenkins-Monroe, 2000; Morrison et al., 1998; Riehman et al., 2000; Williams et al., 2004; Zule et al., 2002), and barriers to treatment (Riehman et al., 2003; Roberts & Nishimoto, 2006; Scott-Lennox et al., 2000; Tighe & Saxe, 2006). Existing literature also has indicated that gender (Beckerman & Fontana, 2001; Messer, Clark, & Martin, 1996), race (Beckerman & Fontana), culture (Aktan, 1999; Bowser & Bilal, 2001; Lewis, 2004), and socioeconomic status (Myers & Gill, 2004; Rosen et al., 2004) are influential factors for this population's treatment entry rates, treatment needs, and treatment outcomes. Nevertheless, less is known about issues specific to African American women within the context of CPS and CJS mandated referrals (Klag et al., 2005) .

Substance-abusing African American women, particularly those who are economically marginalized, are subject to discriminatory policy enforcement (Chibnall et al., 2003; Coyle, n.d.; Zerai, 2002) and unrealistic compliance requirements (Chibnall et al.; Metsch & Pollack, 2005). Furthermore, inadequate assessment by referring agencies has contributed to poor matching of individual needs and services (Metsch & Pollack)

which further exacerbates both presenting concerns and difficulties with treatment compliance.

Recommendations for Treatment Programs and Counselors

African American women who have been mandated to substance abuse treatment experience intrapersonal (Ehrmin, 2001, 2002; Roberts & Nishimoto, 2006) and interpersonal (Riehman et al., 2003; Roberts & Nishimoto) obstacles as well as institutional barriers (Burke, 2002; MacMaster, 2005). For this reason recommendations have been provided for treatment programs as well as for individual counselors.

Treatment programs. Programs accepting African American women with mandated referrals should make efforts to improve communication and collaboration with referring agencies (Amaro et al., 2005). Interagency training and cooperation has been identified as an effective way of improving service delivery and outcomes, advocating for women, and empowering them in their recovery process (Azzi-Lessing & Olsen, 1996; Marsh et al., 2000; McAlpine et al., 2001). It is also important for treatment programs to attend to communication barriers between clients and referring professionals, particularly in cases where clients have experienced frequent turnover of caseworkers or probation officers.

Treatment services working with African American women should evaluate their programs for inclusion of race- and gender- specific services (Howard, 2003). Programs could improve their services to this population by including culturally-affirmative models of parenting (Aktan, 1999; Lewis, 2004), and by assisting African American women with developing social support that reflects their cultural and individual values (Dakof et al.,

2003). Programs that have implemented successful treatment models specifically for the needs of African Americans have focused on community interventions that addressed racism and stigma (Sanders, 2002), and family-inclusive structures (Aktan). Successful strategies for working with substance abusing African American women have included pre-treatment outreach intervention (Dakof et al., 2003) and assisting women with building community and church-based recovery networks (Stahler et al., 2005).

Treatment programs, as well as individual counselors, can improve their services to African American women by evaluating their intake and assessment process. All women entering treatment should be thoroughly assessed for childhood and adult exposure to abuse and violence, trauma symptoms, and co-occurring disorders (Amaro et al., 2005; Gatz et al., 2005; Salasin, 2005). African American women who are mandated to treatment in public programs also are likely to be struggling with significant economic and resource stressors that complicate treatment entry (Heflin et al., 2005; Miller & Neaigus, 2002). A holistic assessment would include a thorough evaluation of physical health (Bernstein et al., 2006; Wyatt et al., 2005; Young & Boyd, 2000) and access to basic resources such as food (Heflin et al.) and shelter (Miller & Neaigus; Mulroy, 2002). Social factors that have been found to impact treatment entry and outcomes for this group, and which should be carefully assessed, include partner attitudes towards drug use and treatment involvement (Riehman et al., 2003), exposure to violence (Josephson, 2005; West, 2002), parenting status (Scott-Lennox et al., 2000), family of origin issues (Dunlap et al., 2004), and social networks (Davis & Jason, 2005).

Furthermore, programs may be better able to support and advocate for individual clients by considering multiple and interacting sources of pressure (Dakof et al., 2003; Marlowe et al., 1996; Marlowe et al., 2001). It is not enough to establish the requirements of the referring agency; women may be experiencing pressure from other agencies as well as from family, partners, and peers who may either support or discourage women from complying with mandated treatment (Marlowe et al., 2001; Young, 2002). Marlowe et al. (2001) recommended assessing mandated clients across three areas: positive and negative types of pressure, internal and external sources of pressure, and perception of pressure.

Finally, programs may be able to improve treatment entry by educating African American women about treatment during the intake process. Important information to address with this population includes support services available through treatment such as housing assistance, childcare, parenting classes, employment, or educational training (Markoff, Finkelstein, Kammerer, Kreiner, & Prost, 2005; Marsh et al., 2000); and opportunities to receive social, spiritual, and emotional support (Brome et al., 2000; Ehrmin, 2005).

Counselors. Lassiter and Chang (2006) found that substance abuse counselors self-identified a need for both increased attention to multicultural issues in supervision and for skill-based training. These needs are supported in the American Counseling Association Code of Ethics (American Counseling Association [ACA], 2005) with recent revisions emphasizing both cultural competence and the importance of client advocacy. As outlined in ACA's Code of Ethics, cultural competence includes culturally sensitive

informed consent (A.2.c), counselor awareness of personal values and biases (A.4.b), attention to cultural biases in diagnosis (E.5.c) and assessment (E.8),and advocating for clients who face barriers to care (A.6).

Counselors may be uncomfortable acknowledging the power differential that exists in relationships with African American female clients who have been mandated to treatment under threat of state sanctions and who also are economically and socially marginalized (Burman, 2004). The quality of the therapeutic alliance has been found to be a significant factor in successful treatment and recovery outcomes (Grosenick & Hatmaker, 2000; Kasarabada, Hser, Boles, & Huang, 2002). Counselors must acknowledge the possibility that they are seen as agents of the state and take appropriate steps to directly address issues of trust and power (Burman, 2004).

Counselors can provide indirect help to this client population by addressing discriminatory policy enforcement at the social service (Chibnall et al., 2003) and legislative levels (Kansal, 2005). They also could be effective change agents by providing consultation and training services to referring agencies, with the aim of reducing stigma, increasing recognition of underlying client issues, and providing a guide to more appropriate referrals. Counselors are strongly encouraged to look for emerging studies, advocate for additional research with this population, and to develop collaborative relationships with researchers. Following the practitioner-researcher model, treatment programs and counselors may want to consider engaging in some of the following recommendations for future research.

Recommendations for Research

African American women represent a small portion of overall treatment admissions with distinct needs and concerns related to substance use, treatment, and mandated treatment referrals. Additional research is needed to better understand African American women's experiences with mandated treatment, especially as pertains to treatment entry and outcomes. The most immediate research need is to develop a better understanding of population-specific concerns as well as within-group differences. Exploratory studies are likely to be most helpful in this area (Lincoln & Guba, 1985). Additional research needs include population-specific epidemiological surveys, large-scale and longitudinal treatment outcome studies, and research that will support empirically-based interventions.

Ethnographic case studies and naturalistic inquiry have been recommended as a method for identifying population-specific issues and concerns, as well as within-group differences (Lincoln & Guba, 1985). African American women share an ethnic heritage and historical context, as well as life experiences related to being dually oppressed by racial and gender discrimination (Burke, 2002; Collins, 2000; Constantine, 2006). Qualitative within-group studies that focus on identity, resiliency, and cultural perspectives may shed further light on African American women's perceptions of substance use and abuse, treatment, and state-imposed sanctions. Other factors that would benefit from qualitative within-group studies include attention to multidimensional aspects of pressure and motivation (Marlowe et al., 2001), protective factors and resiliency, perceptions of treatment and treatment staff, experiences with treatment, and

perceived barriers to and benefits of treatment. Practitioner-researchers who are actively counseling and have established relationships with African American women mandated to treatment are well-positioned for conducting such studies.

It is difficult to gain a comprehensive understanding of within-group differences in drug use prevalence and patterns of African American women based on existing studies and surveys (Kip et al., 2002; Turner & Wallace, 2003). One research need is large-scale epidemiological surveys of African American women that look for within-group variations based on culturally relevant variables such as spirituality, social support, socioeconomic status, and racial identity measures. Studies that track this population from referral through treatment entry, completion, and extended recovery would likely contribute to improving treatment efficacy and outcomes (Klag et al., 2005).

Finally, there is a need for population-specific substance abuse intervention studies and treatment program evaluation (Klag et al., 2005). Several programs and interventions have shown promising results with African American women within a single community or region (Aktan, 1999; Dakof et al., 2003; Sanders, 2002; Stahler et al., 2005). It would be helpful to conduct replication studies of these programs and also of isolated components from within those programs (e.g. the use of role models, church-based mentors, and community engagement). A comprehensive plan of research that moves beyond quantifying mandated treatment compliance and focuses on the specific needs and concerns of substance abusing African American women will likely contribute to improved outcomes.

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CHAPTER 2

WANTING TO BE HEARD: AFRICAN AMERICAN WOMEN'S PERCEPTIONS OF MANDATED REFERRAL TO SUBSTANCE ABUSE TREATMENT

There is growing national attention to the interaction between mental health and sociocultural factors including gender, race, ethnicity, and socioeconomic status (SES; American Psychological Association [APA], 2003; United States Department of Health and Human Services [USDHHS], 2001). This is equally true in the field of substance abuse treatment where studies have identified interactions between these sociocultural factors and treatment efficacy (Amaro et al., 2005; Brady & Ashley, 2005; Lewis, 2004; MacMaster, 2005; Substance Abuse and Mental Health Services Administration [SAMHSA], 2003, 2005a, b; Walton, Blow, & Booth, 2001; Wechsberg, Lam, Zule, & Bobashev, 2004). Given that African American women evidence low treatment entry follow-through (Siqueland et al., 2002) and high treatment drop out rates (King & Canada, 2004; Scott-Lennox, Rose, Bohlig, & Lennox, 2000) it will be important to learn more about circumstances that both facilitate and challenge mandated treatment entry for this population.

It is especially important to attend to sociocultural factors in the treatment of substance-abusing African American women who are marginalized by race, gender, and economic status (Burke, 2002; James et al., 2003; McAdoo, 2002) and who experience

unique stressors (Amaro et al., 2005; Ehrmin, 2001) and strengths (Brome, Owens, Allen, & Vevaina, 2000; Wright, 2003) that influence treatment efficacy. Studies addressing substance abuse treatment issues for African American women have identified within-group barriers to treatment entry and retention (Allen, 1995; MacMaster, 2005; Roberts & Nishimoto, 2006; Wyatt, Carmona, Loeb, & Williams, 2005), effective treatment interventions (Stahler et al., 2005; Washington & Moxley, 2003; Wechsberg et al., 2004), and culture-specific care needs (Brome et al., 2000; Curtis-Boles & Jenkins-Monroe, 2000; Ehrmin, 2005; Wright, 2003).

Individuals experience pressure to enter substance abuse treatment from a variety of sources including family, social (e.g. intimate partners, or friends), and substance abuse severity (Marlowe, Merikle, Kirby, Festinger, & McLellan, 2001; Maxwell, 2000). Marlowe et al. (2001) also identified pressure from financial circumstances, employers, and medical and mental health workers. Another source of external pressure is from legal and other punitive sanctions imposed by state and federal agencies (Klag et al., 2005; Maxwell, 2000). In the 2004 Substance Abuse and Mental Health Services Administration (SAMHSA, 2006) national survey of public substance abuse treatment facilities 36% of all referrals were from the criminal justice system (CJS), and an additional 10% came from community referrals which included social service agencies. In a national survey of adult female treatment clients admitted between 1992 and 1997, 27% of the population surveyed was referred through the CJS and an additional 11% from social service agencies (Ashley, Sverdlov, & Brady, 2007).

Government statistics and research sample populations indicate that CJS system referrals were predominantly male (Gregoire & Burke, 2003; Young, 2002), whereas child protective services (CPS) referrals were more likely to be female (Brecht, Anglin, & Dylan, 2005; Rittner & Dozier, 2000). While African American females age 18 years and over evidenced illicit drug use rates (4.5%) similar to Hispanic (4.4%) and lower than White females (6.3%; SAMHSA, 2005a) they were more likely than females of other racial/ethnic groups to be state-mandated to treatment (Administration for Children & Families [AFC], 2006; Burke, 2002; Chibnall et al., 2003; McAdoo, 2002; Zerai, 2002).

There are a number of factors contributing to higher rates of mandated referrals among substance-abusing African American women. These include disproportionate rates of poverty (Burke, 2002), drug use patterns (Kansal, 2005), and race bias in social policy and implementation (Chibnall et al., 2003; Constantine, 2006; Zerai, 2002) all of which increase the likelihood of exposure to government surveillance and, consequently, CPS and CJS interventions (James et al., 2003; MacMaster, 2005; Turner & Wallace, 2003). Thirty percent of single African American females are living below the federal poverty line, as are 40% of families headed by single African American women (United States Census Bureau, 2006). These results represented a 10% higher poverty rate than that for non-Hispanic white females. In addition, African American women evidence lower educational attainment and higher rates of unemployment and poverty than White women in both rural and urban settings (Boyd, Phillips, & Dorsey, 2003; Jerrell, Wieduwilt, & Macey, 2002; National Poverty Center, 2006).

Although African Americans account for only 13% of the overall population (United States Census Bureau, 2001) they comprise 40% of adult recipients of Temporary Aid to Needy Families (TANF; AFC, 2006). Changes in federal welfare policy have put pressure on states to reduce the number of welfare recipients and have also given states the freedom to administer sanctions of their choosing (Metsch & Pollack, 2005). Accordingly, disability, welfare, and ready-to-work programs have implemented mandatory alcohol and drug screenings for individuals seeking benefits (Beatty, 2003; Brady & Ashley, 2005; Metsch & Pollack, 2005). Individuals with positive screens are likely to be mandated to treatment or face reduction or loss of benefits.

Racial disparities in the use of sanctions by state agencies have been attributed to demographic variations in drug use patterns and to illicit drug sentencing policies (Coyle, n.d.; Kansal, 2005; United States Sentencing Commission, 2007). A contributing factor to frequency and severity of sentencing is disproportionate crack cocaine use among African American women (Hawthorne & Henderson, 2002; SAMHSA, 2003, 2006; Williams, Juon, & Ensminger, 2004). African American females account for 7% of all public treatment admissions, but 21% of admissions with crack cocaine as the primary substance of abuse (SAMHSA, 2006).

Individuals who use crack cocaine are subject to excessive state intervention. In response to the rise in crack cocaine use during the 1980's, federal drug sentencing legislation targeted possession and distribution of crack cocaine for greater enforcement, increased prosecution, and more severe sentencing (Coyle; Kansal; United States

Sentencing Commission). Despite lack of empirical evidence to justify these policies, overly severe penalties for minor offenses continued and are only now being addressed in the legislature (United States Sentencing Commission).

Combined with the prevalence of crack cocaine use among African Americans, these sentencing policies have contributed to racial disparities in the prison population as well as in mandated treatment referrals (Hawthorne & Henderson, 2002). Over the past two decades, drug use has increased among women of childbearing age (Bogart, Stevens, Hill, & Estrada, 2005) as has the number of women arrested and incarcerated for drug related offenses (Auerhahn, 2004; Burke, 2002). African American women are disproportionately referred to the CJS for drug related-offenses, and receive more severe sentencing (Amaro et al., 2005; Henriques & Manatu-Rupert, 2001). The majority of females prosecuted for prenatal drug abuse in the United States are African American (Zerai, 2002) and they also represent the majority of incarcerated females (Henriques & Manatu-Rupert).

Although there is no consistently reported national data on the race/ethnicity of parents reported to child welfare, there are some indications of racial bias in CPS reporting and enforcement (Azzi-Lessing & Olsen, 1996; Chibnall et al., 2003; Rittner & Dozier, 2000. Pregnant African American women evidenced approximately double the rate of past month illicit drug use (8%) of White (4.4%) and Hispanic (3%) females (SAMHSA, 2005b). However African American women were anywhere from 3 to 10 times more likely than their White counterparts to be reported to child welfare and to have their children removed from their custody (Azzi-Lessing & Olsen; Rittner &

Dozier). A survey of CPS workers (Chibnall et al.) found that the majority perceived pervasive racism within the system (i.e. policy structure, implementation, and enforcement) and among individual child welfare workers.

African American Women and Treatment Entry

African American women may have greater difficulty accessing and entering substance abuse treatment services (Tighe & Saxe, 2006) and also evidence higher drop-out rates (Scott-Lennox et al., 2000). In a large-scale study of treatment engagement factors Siqueland et al. (2002) found lower rates of treatment entry follow-through among individuals who were unemployed and African American. Being female and African American also has been identified as a predictor for early treatment drop-out (King & Canada, 2004) as has being a parenting African American female (Scott-Lennox et al., 2000). In this section treatment entry barriers experienced by substance abusing African American women are reviewed.

Practical barriers to substance abuse treatment faced by African American women seeking substance abuse treatment include waiting lists and lack of insurance (Allen, 1995; MacMaster, 2005), childcare issues (Rosen, Tolman, & Warner, 2004), housing instability and homelessness (MacMaster), and transportation (MacMaster; Marsh, D'Aunno, & Smith, 2000; Rosen et al.). Under-resourced communities have been found to provide insufficient or inadequate services (Tighe & Saxe, 2006; Walton et al., 2001). Substance-abusing African American women have identified significant help-seeking barriers that relate to problem severity and identification (Roberts & Nishimoto, 2006). Intrapersonal barriers include internalized shame and guilt at failing to fulfill the maternal

role (Ehrmin, 2001; Finkelstein, 1994) and fear of relinquishing substances that serve as a means of emotional coping (MacMaster).

Family and social concerns also have been identified as significant barriers to treatment entry among African American women (MacMaster, 2005; Wyatt et al., 2005).They have expressed concern that treatment will interfere with their obligation to care for dependent others, including extended family members (Wyatt et al., 2005). The potential of jeopardizing one's parental rights (Allen, 1995; MacMaster, 2005), either due to inpatient admission or to ongoing positive drug and alcohol screens (Bogart et al., 2005; Finkelstein, 1994; Powis, Gossop, Bury, Payne, & Griffiths, 2000), is an additional barrier to entering services. Scott-Lennox et al. (2000) found that, while African American women were more likely to enter treatment, they also were more likely not to return to or complete treatment, in part due to childcare responsibilities. African American women who are HIV-positive or have a comorbid mental health disorder have reported fear of being stigmatized in their family or community (Wyatt et al.) and of being seen as dysfunctional (Finkelstein).

Substance-abusing African American women have reported an overall lack of trust in social and mental health service professionals (Metsch & Pollack, 2005; Roberts, 1999) and have reported both fear and distrust of substance abuse treatment staff (Roberts & Nishimoto, 2006). In a mixed gender study Ward (2005) found that, before engaging in treatment, low-income African American mental health clients assessed a therapist's ability to relate to racial, ethnic, and gender concerns and to provide a safe and trustworthy climate. Attending to the most immediate needs of African American women

entering treatment has been found to increase early engagement (Brown, Melchior, Panter, Slaughter, & Huba, 2000).

Mandated Treatment Entry

Studies examining mandated treatment have largely been conducted with male and/or mixed gender and race samples located in the CJS (Butzin, Saum, & Scrapatti, 2002; Bouffard & Taxman, 2004; Gregoire & Burke, 2003; Kelly, Finney, & Moos, 2005; Klag, 2005; Marlowe et al., 1996). However, some attention has been given recently to women with mandated treatment referrals.

In a large-scale study (*N* = 4,156) Grella, Hser, and Huang (2006) looked specifically at mothers in substance abuse treatment and found that those with CPS mandates had less overall substance abuse severity, but greater economic instability than those who were self-referred. Although this was a mixed-race/ethnicity sample between-group differences were not reported, as found in reported results from studies with similar populations (Mullins, Suarez, Ondersma, & Page, 2004; Rittner & Dozier, 2000). This is unfortunate given indications that African Americans evidence significantly lower mandated treatment entry (Siqueland et al., 2002) and completion (Butzin et al., 2002; Dannerbeck, 2000) rates than Whites. Furthermore, Scott-Lennox et al. (2000) identified both between and within-group differences by race/ethnicity in a large-scale sample (*N* = 3,309) of women in treatment, including those with CPS involvement (*n* = 496). The authors found that being African American predicted lower completion rates, although African American women with children in foster care were more likely to complete treatment than those who retained custody.

African American Women and Mandated Treatment Entry

Few studies are available specifically exploring the efficacy of mandated treatment with African American women; these include Dakof et al. (2003), Roberts and Nishimoto (2006), and Lewis (2004). Dakof at al. found that an enrollment intervention program for substance-abusing African American mothers with CPS referrals (N = 103) almost doubled entry rates, but did not significantly improve long-term treatment retention. Roberts and Nishimoto collected both quantitative and qualitative data from participants (N = 221) regarding experienced barriers to entering treatment. However, treatment barriers were pre-identified by the researchers from existing literature and the service provider. Lewis used a womanist framework to obtain qualitative data from African American women (N = 8) about their participation in treatment. Although mandated referral was not a sampling criterion, feeling coerced into treatment (i.e. external sanctions without internal motivation) was identified as a barrier to entry and engagement.

Theoretical Orientation

Because African American women encounter significant personal and social consequences resulting from oppressive and discriminatory policy implementation (Chibnall et al., 2003; Burke, 2002; James et al., 2003; Zerai, 2002), a Black feminist framework was selected to inform the research design for this study (Banks-Wallace, 2000; Collins, 2000). Black feminism affirms the values, experiences, and ideas of African American women from an Afrocentric perspective, rather than in comparison to White Eurocentric and patriarchal positions (Collins, 2001).

The terms womanist and Black feminist have been used interchangeably (Banks-Wallace, 2000; Braun Williams, 1999; Collins, 2000). Alice Walker (1983) used the term womanist to describe a valid moral standpoint growing out of experiences of oppression and to present a holistic vision of community relations (male and female, love for other women). Banks-Wallace noted that Black feminism is part of a larger critical paradigm wherein "knowledge is assumed to be value laden" (p. 37) and shaped by historical, political and sociocultural factors. The term Black feminism has been used here to indicate a holistic framework for identifying, exploring, and understanding the standpoint of African American women (Collins, 2001).

As noted by Collins (2001), "Investigating the subjected knowledge of subordinate groups…requires more ingenuity than that needed to examine the standpoints and thoughts of dominant groups" (pp. 252). Therefore, Collins (2001) proposed a set of four standards for assessing knowledge and methodology based on her synthesis of Black feminist thought: (a) lived experience as a standard for establishing credibility, (b) dialogue as a means of constructing, sharing, and assessing knowledge, (c) the relevance of individual uniqueness, emotionality, and empathy, and (d) an ethic of personal accountability for knowledge claims. These standards served as a framework for designing and implementing this study as well as for data analysis and interpretation.

Purpose of Study

There has been an increase in literature calling mental health professionals to account for poor delivery outcomes among marginalized populations, including African American women (American Psychological Association, 2003; Constantine, 2006; Lott,

2002; Smith, 2005; Turner & Wallace, 2003; Ward, 2005). Accordingly, the purpose of this study was to explore African American women's perceptions of and experiences with state-mandated treatment referrals as pertains to treatment entry.

The majority of substance abuse studies inclusive of African American women have been comparative studies that have utilized etic (i.e. from the perspective of an outside observer) data collection methods (Turner & Wallace, 2003). One concern with using purportedly objective measures with oppressed and marginalized populations, is that researchers may reinforce negative racial and gender stereotypes (Roberts, Jackson, & Carlton-LaNey, 2000). Language is one way in which traditional research methods impose Euro-centric values and interpretations (Landrine et al., 1995). Wisdom conveyed through culture-specific language, expressiveness, and emotionality may be lost or misinterpreted through the lens of traditional data collection and analysis methods (Constantine & Sue, 2006).

James and Foster (2003) asserted that the use of a narrative approach provides access to "certain aspects of the client's culture which contribute to their sense of self" (p. 76) and which "may only be understood through gaining an understanding of 'thick' cultural descriptions which deal with 'particular,' non-universalizable subject-matter" (p.76). One means of working towards this goal is to place female African American research participants in a position of expertise, inviting their lived experience to inform improvements in prevention, intervention, and research (Landrine, Klonoff, & Brown-Collins, 1995). This study attempted to explore specific sociocultural factors (gender, race, and SES) as well as women's perceptions of individual, group, and systemic issues

that influence mandated treatment entry. Therefore, interview questions were semi-structured (see Appendix C) and presented using open-ended prompts and informal dialogue.

Method

The design for this qualitative study was grounded in Black feminist epistemology as described by Collins (2000) and operationalized using naturalistic inquiry as outlined by Lincoln and Guba (1985). Because naturalistic inquiry emphasizes *value-resonant inquiry* (i.e. problem, context, theory, paradigm, and mode of inquiry must be congruent in order to present meaningful results; Lincoln & Guba) it is well suited to operationalizing a study grounded in Black feminist thought. Naturalistic inquiry is congruent with the exploratory nature of the study regarding the role of perception and constructed reality. The research design was approved by the Institutional Research Board (IRB) at Georgia State University. All data for this study were collected between April and July of 2007.

Within the paradigm of naturalistic inquiry, versions of the truth are discussed in terms of levels, or modes, of reality (Lincoln & Guba, 1985). Collins (2000) stated that, "…choices about whom to trust, what to believe, and why something is true are not benign academic issues. Instead, these concerns tap the fundamental question of which version of truth will prevail." (pp. 252). The naturalist paradigm asserts that reality is constructed or created by those asserting knowledge claims. Therefore this paradigm requires a mode of inquiry that accounts for multidimensional factors, participatory constructions, and tacit knowledge (i.e. intuitive, sensed; Lincoln & Guba). The

epistemological standards of Black feminist thought provide a framework for the exploration of culturally constructed reality. Collins argued that African American women may perceive and define reality through shared experiences (historical, political, and sociocultural) that "become the collective wisdom of a Black women's standpoint" (pp.256).

Participants

A total of 17 participants were recruited via convenience sampling at one outpatient and two residential women's substance abuse treatment programs located in a southeastern urban area. Convenience sampling is based on participant accessibility (Schensul, Schensul, & LeCompte, 1999) and was appropriate for this study given the inherent difficulty of locating African American women who have been referred to, but have not yet initiated treatment entry. Recruitment continued until saturation of data was evident in concurrent data analysis. The resulting sample size is considered sufficient for reaching redundancy, or exhaustion of emergent data (Lincoln & Guba, 1985), in exploratory studies using in-depth interviews with adult populations.

Treatment programs were selected as recruitment sites based on client demographics (age, race/ethnicity, referral status), program type (either residential or intensive outpatient), and fee scale (no-fee or sliding scale). Three programs participated in data collection; a fourth program gave permission for data collection, but did not respond to multiple requests to set up interviews.

*Recruitment Procedure*s

The primary investigator (PI) visited each site to describe the study and recruit participants. Volunteers were screened on site for the following inclusion criteria: (a) 18 years of age or older; (b) identify as Black and/or African American; (c) mandated or perceived a mandate from a local or state authority (court and/or child protective services) to attend substance abuse treatment.

Participants were asked to provide a pseudonym to be used for screening, data collection, and publication purposes. They were informed of the study purpose, content (informed consent, demographic form, and interview), and expected length of participation. They also were informed that women who participated in all or any portion of the interview would be compensated $20. For the convenience of participants, all interviews were conducted at treatment locations in private meeting spaces.

Participant Demographics

All participant demographic data were collected via self-report prior to initiating the interview. Of the 17 women who participated in the study, 12 had open CPS cases that required treatment involvement and 5 were referred to treatment through CJS probation. Participant ages ranged from 20 to 47 years (M = 32.6) and all identified as Black/African American with one exception (Black/Puerto Rican). Two had been married and divorced, one was engaged, and four reported other significant relationships (i.e. long-term boyfriends); two participants openly identified as gay/lesbian (not currently partnered). Approximately half of the participants reported a history of financial self-sufficiency with no use of public assistance. However, at the time of the interview only

four were employed and 11 were receiving some sort of public assistance. The majority of participants had completed high school or obtained a general education diploma (*n* = 12) and six had completed some college.

Nearly all of the participants reported having children (*n* = 15); ages of their children ranged from one month to 18 years and the number of children per participant ranged from one to eight (*M*=4.1). Four participants had children in their custody, 10 had children in the care of family members, two had signed over custody to a child's biological father, and eight had children currently placed in foster care (note that some participants had children in more than one custody placement). Four women had children with profound developmental disabilities, several reported children with chronic asthma, and one reported twins that died at birth.

The most frequently reported primary drug of choice was crack cocaine (*n* = 10), followed by marijuana (*n* = 6), powder cocaine (*n* = 3), polysubstance use (*n* = 3), and alcohol (*n* = 2). All participants reported at least one life-time attempt at abstinence, often during pregnancies. Length of abstinence periods ranged from a few weeks (*n* = 1), to six-plus months (*n* = 6), to one or more years (*n* = 7). More than half of the participants (*n* = 11) reported two or more prior admissions at time of interview.

Data Collection

All participant data for this study were collected by the PI (European American, female), a doctoral student in counselor education. The research team was comprised of the PI and two research assistants who were masters-level graduate students (African American, female) in a professional counseling program. The research assistants received

training in transcribing, coding, and analyzing qualitative data for this project. The research team transcribed, coded, and analyzed all data with the exception of three transcriptions completed by volunteers outside the project and proofread by the PI.

Participant Data

The PI reviewed the informed consent verbally and in writing with volunteers (Appendix A) who gave verbal consent to participate in the study. Participants were then given a copy of the demographic survey (Appendix B) and offered the option of completing it on their own or interview-style (questions read aloud by PI who recorded responses). The demographic survey included questions regarding age, ethnicity, partnership and parenting status, household composition, education and income levels, welfare benefits status, employment status, primary drug of choice, perceived consequences of substance use, referral source, and treatment history.

Following completion of the demographic survey, the PI initiated an in-depth audio-recorded interview which ran 60 to 120 minutes in length (M = 99). Interviews were semi-structured to allow for exploration of the research question through informal, conversational data collection in which participants were acknowledged as the expert in understanding and assigning meaning to their experience (Oakley, 1981; Reinharz, 1992). Interviews were structured using open-ended questions (Appendix C) designed to explore perceptions, internal and external influences, and sociocultural factors (race, gender, SES) as pertained to women's experience with mandated treatment referrals (see *Data Analysis* for further description).

Field Notes and Reflexive Journals

After each interview, the PI completed *field notes* (LeCompte & Schensul, 1999a) which included descriptive observations of participant appearance, behavior, affect, and interaction. Notes also were taken describing the interview location and setting, the PI's inferences and emotional reactions during the interaction, and any unusual circumstances that may have influenced data content or collection (Lincoln & Guba, 1985). In addition to field notes, the PI and research assistants maintained ongoing *reflexive journals* which included a record of daily activities, and emotional and intuitive responses to the data collection and analysis process (Lincoln & Guba). The PI's reflexive journal also included a record of consultations and of methodological decisions made throughout the data analysis process.

Data Analysis

The primary data set for this study consisted of 17 in-depth interviews representing one-time contacts with participants. Interviews were digitally recorded and transcribed verbatim including the emotional emphases used by participants (i.e. through use of textual formatting and descriptive insertions from transcriber). Transcripts were then printed out in hard copy for coding purposes. The research team created word processing spreadsheets for each transcript to track codes by line number; after coding was completed these individual documents were merged into a master spreadsheet. Supplementary data (and methods of analysis) included participant demographic surveys (descriptive statistics), interviewer field notes, and research team logs (cross-checked with emergent codes).

Data analysis included both deductive and inductive approaches (LeCompte & Schensul, 1999a; Lincoln & Guba, 1985). Preparation for data analysis included a thorough review of theoretical and empirical literature, and the identification of themes specific to this population and issue. This review informed deductive coding for: sociocultural variables (race, gender, and SES; Beatty, 2003; Burke, 2002; Constantine, 2006; Ehrmin, 2005), individual perceptions (Marlowe et al., 2001), and culture-specific content and forms of expression (Collins, 2000). Inductive analysis was used to identify new themes, revise deductive codes, and to ensure the inclusion of contradictory data (Lincoln & Guba, 1985). Both deductive and inductive data analysis were operationalized using a three-level process (described below in greater detail) established by LeCompte and Schensul (1999a).

Data analysis began with a protocol assessment phase during which the first four interviews obtained were transcribed by the PI and reviewed, in conjunction with the original audiorecording, by the research assistants and also by consultants. The purpose of this assessment phase was two-fold. First, to ensure that the interview protocol was effective in eliciting and exploring data related to the research questions. Second, to ensure that the PI was effectively, accurately, and empathetically responding to participant narratives. The latter was a means of assessing for interviewer adherence to the standards of Black feminist epistemology (Collins, 2000). Feedback from reviewers was used to inform adjustments to the phrasing and sequencing of interview questions as well as to PI facilitation of the interview. Upon completion of the protocol assessment the

PI conducted all additional interviews; these were distributed between research team members for transcription.

Step 1. Item-Level Analysis

The item-level of analysis is a process of identifying a comprehensive list of individual units of data; this process may be ongoing throughout data analysis (LeCompte & Schensul, 1999a).The research team reviewed transcriptions one at a time concurrent with data collection. After each team member independently reviewed a transcript and compiled their own list of items, the team met to compare and discuss findings, and to develop a comprehensive item list for that transcript. Items were kept as close as possible to specific and concrete examples (i.e. using participant language) from transcripts in order to reduce interpretive drift (LeCompte & Schensul, 1999a). Item analysis continued on a transcript-by-transcript basis until saturation (items were repetitive, with no new significant findings over a minimum of three consecutive transcripts), which was reached upon review of the 10th transcript.

Step 2. Pattern-Level Analysis

Pattern-level analysis is a process of examining emergent data for coherent groups of items, or patterns (LeCompte & Schensul, 1999a).Throughout item-level analysis the research team identified patterns by item frequency, similarities, omissions, or by participant identification of patterns (LeCompte & Schensul, 1999a). Particular attention was paid to the latter; participant-identified patterns were represented using their language. Upon completion of item-level analysis and before structural-level analysis, the

research team cross-checked items against patterns to ensure that all individual data units were accounted for within the established patterns.

Step 3. Structural-Level Analysis and Coding Agreement

This step was conducted upon completion of item- and pattern-level analysis. The research team looked for emergent relationships between patterns (themes) that pertained to the research questions. Team members met to discuss themes and to develop a coding system (a structural outline of themes and sub-themes relevant to the research question; LeCompte & Schensul, 1999a). Data analysis throughout this inductive three-step process included constant comparison of participant language in order to establish "consistent identifiers" (LeCompte & Schensul, 1999a). Whenever possible, these identifiers were included in code definitions.

Step 4. Establishing Interrater Agreement

Upon completion of the above steps team members independently applied the coding system (See Appendix D) to original data sets, meeting after each transcript was coded to come to consensus on any discrepancies in the codes or code definitions. After re-coding three transcripts there were no significant differences between coders in interpreting or applying the coding system (range of 90-95% interrater agreement per transcript; Bakeman & Gottman, 1986). The remaining transcripts (n = 14) were divided among the three team members for coding. As a check, each coder also reviewed 10% of the transcripts being reviewed by the other two coders (range of 93-96% interrater agreement per transcript).

Interpretation of Findings

Data interpretation was conducted by the PI and reviewed through peer debriefing, and faculty consultation. Feedback from all parties was used to inform the final interpretation of data. The final version of the coding system was validated through debriefing with research assistants as well as by comparing the system with a review of the PI's field notes and reflexive journal.

Trustworthiness

Lincoln and Guba (1985) noted that "objectivity in its pure form is an unattainable state" (p. 108) and recommended specific criteria to improve the trustworthiness of naturalistic inquiry. These criteria (credibility, transferability, dependability, and confirmability) serve a similar purpose as those used in conventional quantitative research (respectively: internal and external validity, reliability, and objectivity). Procedures for operationalizing these criteria follow those recommended by Lincoln and Guba, and are described in this section.

Credibility

A study is considered credible when sufficient steps are taken to ensure that findings accurately reflect the experience of participants (Lincoln & Guba, 1985; Shensul et al., 1999). Shensul et al. (1999) describe several validity concerns specific to ethnographic research. Several steps were taken in the design, implementation, and data analysis for this study to address researcher bias (Morrow, 2005; Schensul et al., 1999) and observer effects (Schensul et al., 1999). These steps included: having African American women currently enrolled in mandated treatment serve as reviewers for all

research documents and protocol before implementing the study, and interviewing participants in a setting of their choice. Use of multiple treatment sites provided a check against the possibility of site-specific treatment culture. The research assistants also reviewed research protocol before initiating the study, and provided critical insights for the PI during debriefing meetings held approximately bi-weekly throughout data collection and analysis. Expert consultation was sought for review of research protocol, data analysis, and data interpretation. Ongoing analysis of original transcripts by the research team provided an additional check against researcher bias, both in data collection procedures and data analysis.

Additional steps taken to ensure the credibility of this study included triangulation of data sources, peer debriefing, and negative case analysis as recommended by Lincoln and Guba (1985). *Triangulation* allowed for data to be cross-checked, and was accomplished in this study through the use of multiple methods (participant interviews, demographic surveys) and data sources (PI field notes, reflexive journals, professional literature). *Peer debriefing* is a means of probing researcher bias, evaluating working hypotheses and methodological procedures, and assisting the researcher with retaining a comprehensive perspective (Lincoln & Guba). The master's level research team members served as peer debriefers for the PI with debriefing meetings scheduled throughout the data collection and analysis process. All members of the research team kept separate records of these meetings for use in the auditing process. *Negative case analysis* is a means of using disconfirming evidence to redefine and expand working hypotheses (Lincoln & Guba). The research team continuously analyzed data for findings that did not

"fit" developing hypotheses, and employed a consensus process to establish themes that were inclusive of all findings.

Transferability

Lincoln and Guba (1985) noted that it is the researcher's responsibility to accurately and thoroughly report findings, setting, and context, whereas the reader is responsible for determining transferability for their own use. In reporting results of this study, attention was given to facilitating transferability by reporting sufficient participant data, including variety and disconfirming evidence (Morrow, 2005). Data reported from this study includes: descriptions of the research team, participants, and settings; verbatim participant quotes; and demographic survey data.

Dependability & Confirmability

This study included use of an *audit*, as recommended by Lincoln and Guba (1985) to determine dependability (examination of the investigative process) and confirmability (examination of the inquiry outcomes). The audit consisted of a review of all records kept related to the implementation of the research design, particularly those documenting the methodological decision-making process. The *audit trail* (Lincoln & Guba) included all raw data (original recordings, surveys, and field notes); data analysis products; all revisions of the coding manual; and process notes including journals from the PI, research assistants, and peer debriefings.

The auditing process followed Halpern's five stages (as outlined in Lincoln & Guba, 1985). Prior to implementing the study, the PI and auditor met to establish the auditing protocol (goal of the audit, records to be included in the audit trail, auditor's

role, logistics, time limits, expected outcomes). The auditor periodically reviewed the methodology and findings, and conducted a final audit to establish that conclusions were clear, logical, and were grounded in original data. The final audit also served to assess for researcher bias, especially as pertains to the potential for cross-cultural misunderstanding and misinterpretation (Landrine et al., 1995).

Results

The coding hierarchy contained four themes (Level 1 codes; see Appendix D) relevant to participants' treatment entry: (a) perceptions of mandated substance abuse treatment, (b) influences on treatment entry, (c) telling our story, and (d) advice to counselors (see Appendix D). The data within each of these themes were organized into second and third-level codes. Each of these themes and sub-themes has been illustrated using excerpts from the original interviews. Participants are identified with self-selected pseudonyms so that the reader may track both collective and individual narratives. Following Collin's (2000) Black feminist standards for research involving Black women, individual expressiveness (i.e. volume and tone of voice, phrasing) was explored during interviews and was included in coding, analysis, and interpretation. Therefore, participants' emotional emphases have been noted using underline, italics, and within parentheses.

Perceptions of Mandated Substance Abuse Treatment

Participants reported that they initially welcomed, rejected, avoided, or were ambivalent about being mandated to treatment. Many of the participants, particularly those that initially rejected or avoided treatment, reported a change in perception after

entering treatment (perceived and experienced benefits of treatment participation). Participants' attitudes towards mandated treatment were distinct from their perceptions of and experiences with referring agencies (CPS and the CJS). The most frequent complaints cited by participants were: attitudes of referring CPS and CJS professionals, lack of referral follow-through, and unrealistic CPS and CJS expectations. A commonly held perception was that negative attitudes from professionals were a significant obstacle in the mandated treatment referral process as described by Diamond:

> The more help and support and love that they give, the better off people will be. Cause sometimes people just don't know. The judges and everybody: it is so simple!! To help someone who need help you know what I'm saying?!? A lot of people they don't know that we are used to being put down….we are *used* to hearing negative things. If you stop the *negativity* and come on a different approach it is *so easy*. *I* didn't know it was this easy to change me around. You know, it's easy. It's simple….it don't have to take years and years.

Whether they welcomed or avoided treatment entry, several participants perceived the treatment mandate to be an inadequate response to more pervasive life challenges (e.g. childhood and adult abuse). Tre's statement below is representative of the views of many of the women interviewed:

> Mandating and taking kids and all that is not going to do it….mandating a woman who have a *lifetime* of issues- ok not only is she dealing with things from her childhood, things that happen to her in the streets, you know what I'm saying….a woman go through this for so many *years* and *[CPS]* and *p.o.'s* and *court system*

> expect you to be ***healed***. [slapping her hands together for emphasis] It's not that simple! [exasperated laughter]….God is a good God and he's a forgiving God … but he ain't like that. He gonna come on time, you know what I'm saying? So to me they're asking a bit much when they mandate a woman.

This section will focus on sub-themes that emerged as women currently enrolled in treatment reflected on their overall experience with having been mandated. Participant narratives included data pertaining to sociocultural factors, the need for intervention, and the role of individual motivation (Level 2 codes; see Appendix D).

Sociocultural Factors

Participants were asked to describe the role of sociocultural factors in mandated treatment (Level 2 code; see Appendix D), specifically the influence of race, gender, and socioeconomic status (Level 3 codes).

Race. Participants were asked to describe how race played a role in being mandated to treatment (Level 3 code). For the most part, participants reported a perception that the judicial system (i.e. criminal and drug courts) showed no race bias in mandating treatment. A frequent theme was that "drugs is universal" and therefore, as Nicole said, "If it comes to the kids it don't matter if you blue or purple, they don't care, they *say* they're lookin' out for the best interest of the child so I don't think it has anything to do with race." Others emphasized personal responsibility as in comments from Denise "People hang themselves. Things happen to you because of what you do," and from Lisa "we make our situations for ourselves. Now, true enough, you can have incidences where, you know, people stop you and you get a ticket because you're black.

It happens, okay." However she felt that "it's more likely to happen if you're walking around looking like a drug dealer [laughing] you understand what I'm saying?!"

A few participants did express perceptions of overt racism as a possible factor in treatment mandates. The two participants who openly identified as gay or lesbian were among the few who were unambivalent about perceiving institutional racism. Diamond felt that CPS workers "label every Black woman as a crack head whore" and that because they were "quick to judge more with Black women than they do with another race, we get stuff added on just like police do to a Black man, like put drugs on 'em." Bobbie said that "even though they say that 'the South has changed, the South has changed,' yeah it *changed*: they just made it a lot more undercover now." Diamond believed she was treated more harshly after being assigned to a homophobic caseworker. Bobbie also reported discrimination in sentencing, but perceived that it was because her partner was White: "interracial mate, I think that was the top so far….we got it from the officers, we got it from my family, we got it from the inmates."

Gender. Participants were asked to describe how gender played a role in being mandated to treatment (Level 3 code). Generally, participants did not perceive gender bias to be a factor in receiving treatment mandates, although Lisa felt that "they might have been a little easier on me 'cause I was a female" and that "they could have arrested me [during an earlier encounter with officers] but they didn't. They chose to give me a chance." What did emerge was the significance of women's role as nurturing parent and how some participants perceived that to impact treatment compliance. Tre stated that "okay, with men it's true enough that they might have wives and kids, but the woman is

the one who carry the child and are the ones who hurt when the children hurt" and therefore "a man could walk away any time….they can really focus mainly on themselves." She, along with other participants, felt that it was "a *soul* thing for the mother and child" because "for a woman in treatment her mind- every time, every morning she wakes up, when her children's gone something is always missing. It's like a piece of her soul. [crying] To me that's the difference."

Socioeconomic status. Participants were asked to describe how socioeconomic status (SES) played a role in being mandated to treatment (Level 3 code). All but one of the participants reported experiencing or observing differential treatment based on SES, namely that poor women were far more likely to be mandated to treatment, and were less able to defend themselves or secure appropriate services. The following statement from Mary best exemplifies the views of participants:

> I just see that a poor person don't have as much say so….I just think it's harder in these situations. Because….for a person that got money they can buy a lawyer or buy better things or things that they need which a poor person can't afford. So they just have to suffer with whatever they can get.

The Need for Intervention

Many of the participants perceived that the mandate provided necessary structure and reinforcement for critical life changes which they were unable to implement on their own. Others believed that without the intervention, they would most certainly have died from escalating drug use and related high-risk behaviors. Statements such as these were

coded as participants' perceptions of a need for intervention (Level 2 code; see Appendix D).

The push I needed. For women who recognized their drug use as problematic but had been unable to stop on their own, the mandate was perceived as providing critical leverage to enter treatment (Level 3 code). Denise, who was initially voluntary to treatment, stated that it was helpful to have her probation officer add treatment to her probation requirements (thus making it mandated): "it was good! [laughs] It was more- uh, more reinforcement, you know, in case I get any second thoughts." Tinori also reported feeling positively about the external structure "because sometimes you need structure. You need something that's gonna push you." Vee described the mandate as "the miracle that was gonna help me to get my life back" and stated that if CPS had not intervened "I'd still be out there probably." Many of the participants reported a perception that the treatment mandate was a form of divine intervention:

> I knew in my heart, I wanted to stop. But I didn't know *how* to stop using. And I knew it was gonna come to this time, that's why I stayed tryin' to pray and ask God, and even with me askin' God, once I went to jail… I didn't get mad, I didn't even- yeah I was upset, crazy the first day or so, but after I calmed down and I realized you know, and I had to thank God for even putting me in jail cause at that time I realized that was how he was getting me to stop using the drug. … if you are *out there*, and you are crying *out* for <u>help</u>, like myself and don't know <u>how</u> to stop, then mandating can be a good thing. (Shanterria)

Being mandated to a restricted environment (i.e. residential treatment) was important to Shanterria "cause now you in a place where you can't go and leave when you get ready, you know, you gotta be here and doin' what you need to do and that gets you away from every-*body,* so that could be a *good* thing." For others, having ongoing supervision was perceived as helpful intervention. Lisa stated that "I need two years [on probation] because that's- it's gonna take me about that long to get my shit together. Okay? It's gonna take me about that long to get my life together." Tracey's opinion was unequivocal: "I needed that structure to tell me… 'No, you gotta do it like this, this is how it is and no ifs ands or buts.' I need the structure. I *needed* it."

It saved my life. The treatment mandate was perceived as life-saving (level 3 code) by several participants who felt themselves to be at risk, either because of drug use or exposure to violence. For Lisa, the treatment mandate was perceived not only as a preferable alternative to 30 years in prison, but also as a means of escape from a dangerous lifestyle:

> I need this because….I wasn't happy with my life. Okay. It was scary. Okay I- I've had pistols put to my head. Guys shove their cock down my throat with a pistol to my head at the same time. I've been robbed, I've been arrested….nobody wants to live like that, okay?, it's very sad, okay, so I saw this as an opportunity to- to get out of this and change my life.

Diamond described several troubling experiences with CPS, however still felt that mandated treatment was "a good idea overall, you know. I think it helps people more than, you know, they know. It can save lives. It has saved my life." Shanterria noted that,

although mandated treatment isn't easy ("you jus gotta be strong that's all I can say about mandated"), it's still necessary "cause if I weren't mandated here….I don't know where I would be. Probably be in a grave somewhere. And that's *real* talk." Mary also saw mandated treatment as a lifeline:

> It's the best thing that could've happened. I mean if they didn't have these places…what would- I mean how would they end up? Imagine *how* they would end up. *Dead*. Bottom line. Dead. Cause that's where it's goin'- or in jail. For the rest of your life.

The Role of Individual Motivation

Above all else, participants demonstrated an understanding of the complex relationship between internal and external motivation and the implications for mandating treatment. Participants clearly understood the mechanisms of the change process. When asked about overall opinions regarding mandated treatment, a consistent theme was the significance of individual readiness (Level 2 code; see Appendix D). Mandating women who were not ready or at least willing to try treatment was perceived as being an exercise in futility.

Making sense of it all. Several participants reported difficulty understanding the connection between their drug use behavior and the stated intent of the mandate, and subsequently resisted treatment entry (Level 3 code). Many parenting participants equated problematic drug use with an inability to house, cloth, and feed children as well as failure to keep them safe from violence. For women who were parenting, and who felt

they were being effective providers, it was difficult to make sense of the treatment mandate, let alone the threat of custody removal:

> Because I'm like*, I'm taking care of my kids*. I'm feeding them. I'm clothing them and everything. I didn't ask you for nothing. Why…*how could you say* I'm neglecting *my kids*? You know, that was the hardest part right there for me to try to comprehend: *Treatment for what*? You know…For <u>what</u>? I don't have a problem. I got my own place. I'm raising my kids. I buy them what they need. So why should I…*what are you talking about*? (Tracey)

You gotta want it. Participants expressed frustration and annoyance with imposing mandated treatment on individuals who were in no way ready or willing to enter a program. Participants perceived that external sanctions were sometimes effective in getting women into treatment, however they also believed that without internal motivation the intervention would fail. The following quote from Denise best represents observations made by the majority of participants:

> I mean- I don't see it working <u>at all</u> no matter how much they mandate you, if you're not willing. You gotta *really* want it a hundred percent. Not just going through the motions. Or fakin' it until you make it. It don't work. And- I look at all of these girls here and- and they come here and play around and…. you can tell when they not really into it. And- and I be like [exasperated sigh*] it ain't gonna work*! You can just see it. It ain't gonna work. And the next thing you know, the next week, they're not here. But you *gotta want it*.

Rebelling. For some women, feeling forced into treatment created additional obstacles to treatment entry, namely negative emotional responses (Level 3 code). Several participants reported that external sanctions provoked rebelliousness, even if they were initially open to treatment or some other form of assistance. Bobbie felt that if there had been a way for her to "reach out and get that help without police being involved, without [CPS] being involved, without being mandated, you know, it probably would've been a lot easier" and that "if you feel like the police is after you and okay, now they gonna find me: no, you're not gonna try and get no help." Tre felt strongly that "when you're making someone do something they're gonna rebel. And that's coming from my self experiences. When I have someone *on* me telling me what to do, I rebel. Because I have someone telling me."

Manifestations of rebelling described by participants included negative attitudes towards caseworkers, refusing to comply with case-plan and probation requirements, and running. Tre felt the problem was that "once you try to control somebody, they gone *run*. Especially an addict. You try to control a addict? They gonna run. Too many rules." Diamond reported that "the first thing people do when they're depressed and down and going through [CPS], they wanta run. They wanta get away….they just wanta be released from all of that."

Influences on Treatment Entry

Participants named a number of individual, social, and systemic factors they perceived as influencing their willingness and ability to enter treatment (Level 1 code; See Appendix D). These were captured in the following Level 2 codes: individual factors,

social support, system interactions, experiences with child custody, and treatment-specific issues.

Individual Factors

All of the participants referred to the importance of understanding the individual and thoroughly assessing their unique circumstances (Level 2 code; see Appendix D). Findings emerged from their narratives to support the role of the following perceived influences on treatment entry at the individual level: substance abuse severity, having choices, internal motivators, and physical and mental health issues (Level 3 codes).

Substance abuse severity. Substance abuse severity was identified as a significant barrier to treatment entry (Level 3 code) for many participants and took precedence over all other motivators, internal and external. Miss Smart, who sought out treatment and had significant social support to help with logistics, perceived that the primary barrier to treatment entry was "*Me*. Me makin' all these excuses. You know me *lyin'* and… jus me. The devil, that demon, that spirit. Just makin' it tough." Participants perceived that active addiction caused cognitive impairment and interfered with decision making, even when their lives and their children were at risk. Mary remembered that:

> There wasn't a day that went by that I didn't think about [my child] and worry and wonder what was going on with him and how he was being treated. I was thinking about it…but then I was kinda out there too….I *knew* that was the only way that I could get my son back, if I completed a drug program, but *then*, I was thinking about how can I just get, my mind was kinda like *twisted*, you know, its just like the drug had more power than me wanting to get my son back.

Participants also perceived that their substance use contributed to thoughts and feelings that prevented timely treatment entry. Tracey explained that CPS and the CJS "fail to realize: drugs- it can have you seein' things a *whole different way*. Especially if you right in the midst of your- the *height* of your addiction" and that "your brain is still comin' down off the dope and you know you seein' [the treatment mandate] as 'oh well, shit I ain't got nothin' else to *live* for' even thought you know- ok I'm gonna go ahead and do this and eventually I'll get 'em back."

Several participants perceived that a person's ability to change decreased as the severity and duration of substance abuse increased. Tre stated that "you do got some women who *want* it, and some who just don't. Just like, look I've been doing this for twenty-five -thirty years I'm *set*." She described these women as "lost children" who had "been out there for so long they don't *know* how to change. They don't know how to go about the steps <u>to</u> change. They got so addicted to the lifestyle that they <u>fear</u> *change*."

Choices. Another factor that emerged as influencing treatment entry was the extent to which participants perceived themselves to have choices (Level 3 code). Being able to choose treatment over more severe consequences or as a way to pre-empt further state sanctions was perceived as facilitating treatment entry. Renaii said that the treatment mandate "wasn't bad. It was just a choice, either jail, or go to the drug court…. I had already done 120 days in jail through drug court and I didn't see myself spending four months in jail." In that context she, like others in the study, was amenable to entering treatment and did so promptly. The choice was even clearer when the option was six months in residential or thirty years in prison – options presented to two of the

participants. Tinori went directly from jail to residential at her request because "it was going to be inpatient, and that I better stay clean. Or I was going back to prison for 30 years. For 30 years. [interviewer: so how did you feel about six months in treatment?] Oh man that ain't nothing! [laughs] Six months?! That's gonna fly by."

A few of the participants entered treatment without a formal mandate from CPS or the CJS and perceived themselves to have freely chosen to enroll. Penelope enrolled pre-emptively in a program because she knew "I would eventually go to court with [the judge] and he was gonna say go to rehab so I just went on and went on my own. They didn't have to make me go." Two others had failed to comply with prior mandates and were attempting to forestall permanent custody loss by admitting themselves. Miss Smart perceived an unstated CPS expectation: "They're not <u>making</u> me go, they're just really trying to see if I can- if I *want* to do it."

Some participants described personal responsibility as an important factor in choosing how to respond to the mandate. Lisa said that she felt "really badly for women that have children, the state has their children," however she emphasized that women should not rebel or fight, but rather "do what you need to do, <u>now</u>, so that it can be easier later, and then make some kind of commitment to just *change* your life." She was willing to comply with her own treatment mandate because "living the way I was living was what led me toward- led me to that. You know, and that was also my choice and my responsibility." Nicole initially fought against referral to residential treatment, but acquiesced after her substance use escalated to the abuse of cocaine: "when they came

back out and *tested* me the cocaine was still in my system. So she said well you gonna have to go to residential; at this time I didn't put up a fight because I knew *I* was wrong."

Compared to participants who perceived themselves to have choice and responsibility, those who felt forced into treatment without choice also reported resistance to treatment entry. One way participants articulated this resistance was by describing themselves as 'hardheaded', as explained by Tracey "I was a hardheaded strong person and I'm the type you tell me not to I'm gonna *definitely* gonna do it." Participants who identified themselves as hardheaded reported that there was nothing anyone could have said or done to encourage them to enter treatment. Mary said that "it's hard for me to listen. I hear you but I can't just go on and do it, it's like I have to do things for myself, that's just the way I've been in my life, all my life I been that way." She noted that this stubbornness persisted despite "everything my husband told me, everything my momma told me [sigh] it happened [laughing] so I see….you was right, I was wrong. And I wish…I woulda listened to you but I didn't. It's too late now."

Resistance to being forced into treatment was also described as 'having a bad attitude.' As reported by Nicole: "I was always one that I was quick to fight. I don't wanta hear nothing that you got to say, let's rumble, you know so I do *know* ever since twelve that my attitude has just been… just *bad*." She noted that growing up in a military family she "knew who to act out around and I knew who not to act out around….So I did have control….but now when I wasn't *around all them*? And somebody made me *mad*? I didn't care." During the months that preceded her treatment entry, she reported that she

was alternately compliant and defiant with caseworkers, one form of defiance being refusing to follow-through with the treatment mandate.

Internal motivators. Although the literature on mandated treatment has tended to focus on the use of externally-imposed consequences, all participants stressed the importance of internal motivators (Level 3 code). Participant-identified motivators tended to be related to their individual life circumstances including problems related to substance use. Reports of being "tired" of drug use and a drug-involved lifestyle were most closely related to intensity of substance abuse and corresponding severity of risk behaviors, and not to age. Tre (age 27) said she was motivated to enter treatment because "I'm tired of treatment after treatment after treatment. Jail. I've been in situations close to death. I've been raped. I'm tired. I don't want to go through it anymore." Vee directly attributed her motivation to age:

> I think because I'm finally getting older now, I'm 36 now, I've been trying to get clean since I was 17. And when I look out and I see people still out there getting high my age…and they look *tired*. And just the thought of trying to find a way to keep being high after all the money gone, and just, at my age, just, uh, I'm *tired*.

Another internal motivator was a desire for a better life. Tre wanted "a new way of life this time. I wanted to be able to say 'I have a testimony!' I made it through this, I made it through that, and look where I am today." Miss Smart wanted a new life for herself and her daughter (should she successfully regain custody):

> I want a new life, I want something different you know because *I'm* gonna be raisin my daughter and I claim that. I'm gonna raise her and I'm not gonna raise

her in a drug- you know, I'm not gonna be a addict raising my daughter. I'm not gonna do that.

China described her personal motivation within the context of racial and gender oppression. She stated that some of her motivation came from "my ancestors, I mean by just- just by their blood runnin' through my veins I feel like I'm able to accomplish anything I put my mind to." She reported that everyone faces challenges, regardless of race but that as "somebody who has been *raised* in the African American community all her life: a lot of 'em are just damn lazy they just don't like to- they want things handed to em a lot, and I don't want that." She perceived entering treatment as a step towards independence: "I notice that there's more and more African American women that's goin' out here and getting more professional jobs, and gettin' more degrees and, over the years, as time passes, there are more African American women in the colleges."

Physical and mental health issues. Although the minority in this group, some women had significant mental or physical health issues that they perceived as influencing their treatment entry (Level 3 code). Denise was in a shelter trying to get off the streets and into residential treatment, however she reported that health complications slowed down the process: "I was waitin' to….finish all my doctor's appointments and everything that I needed to get my medicine and all that to go into treatment for 30 days to move to the other side [of the shelter]." While waiting on appointments she reported that she ran out of time at the shelter and ended up back on the streets: "I wasn't finished with my appointments so they made me *leave there* and then when I finished my appointments then I could come back to the substance abuse, but I- went back out [using]."

Vee reported health complications that she perceived as both delaying and facilitating her treatment entry. She stated that one program would not accept her "because my diabetes and they're thinking I have to take insulin and everything, they didn't take me in." She stayed with her mother temporarily and tried to find other options: "I started calling other programs, there were waiting lists. I was ready to get this *started*. I was just ready to get this started. So I could get my baby back in 3 to 6 months. I was just ready." During this waiting period she reported abstinence from drug and alcohol use, and also having to be hospitalized for physical and mental health issues. She said that her doctors arranged to keep her admitted for several days until she could enter a residential program: "my doctors really was there for me. They helped me. Even though my diabetes was okay….they just used medical stuff to keep me there until…my bed was, on Monday, everything worked out- on Monday I was in here [the residential program]."

Social Support

The presence or absence of social support, from family, intimate partners, and even children, emerged as another factor influencing treatment entry (Level 2 code; see Appendix D). Women who had some form of treatment-affirmative social support more frequently reported resiliency and resourcefulness in responding to the mandate. Those with little or no social support perceived themselves to be challenged by diminished emotional coping, as well as having fewer practical resources. Denise reported that her substance abuse had alienated her parents and intimate partner leading to a "loss of hope"

and that she found it "hard to kind of snap out of." She believed that "if I had had someone to talk to, you know…a long time ago I would've…it would've helped a lot."

Family and intimate partners often played a pivotal role prior to CPS or CJS involvement that influenced how women responded to the system intervention as well as to the treatment mandate. Several of the participants shared experiences of being reported to CPS by immediate family members or intimate partners (Level 3 code).

Initially these participants felt they had been betrayed, resulting in rejection of the offending person and escalating use. Tre remembered that her mother reported her drug use to "one of the doctors or the counselors that was at [the hospital]….and it more so hurt, than helped" (Tre was not only using while pregnant, but also in a physically abusive relationship). Tracey stated that she initially felt betrayed and alone, but was able to look back and recognize "my mother, my sister tried to help me the only way they knew how…bring [CPS] into it." She felt that her family and partner were close enough to see that:

> I was like on a suicide mission this last…past year, it was like a straight suicide mission with the drugs [crying]. I didn't care. And then when the baby's father he's like, 'What are you trying to do? You trying to kill yourself?' ....it hurt me but I was in a frame of mind where it got to the point where I didn't care.

Mary reported that when she was finally able to forgive her mother for reporting her to CPS, she went home for a visit which finally turned her towards seeking treatment:

> Just being around home, spiritual, remembering the way I was raised, it kind of brought me back to reality. Cuz I totally forgot [laughing]. I mean I was a totally

different person. It was a good reminder, just being, going home, I think I stayed about a week or two and, I decided to get my life back.

Family. When women were asked what most helped them to comply with the treatment mandate, family support was critical (Level 3 code). Tre responded with "the *support* that I have. That my family could have give up on me a *long* time ago." Tinori stated that she received both practical and emotional support from family. She reported that after she persuaded her public defender to ask the judge for a treatment referral, her family picked up from there and "they started calling around to different rehabs and stuff like that. I didn't know nothing about it, see." She perceived that a primary motivation for her entering treatment was the "love that they was giving me really emotionally. The *attention*."

Sometimes family support came from unlikely sources, as in Diamond's brother. Although she said that she generally tries to "stay away from him because he's a drug addict and he sells drugs and he's kinda up to no good *and* he just got out of prison," she also said that he's "a good person" and that it was "very, very important" that he went with her to her intake assessment because typically "he don't do nothing with me." Participants also described how important it was to know that their children were supportive of entering treatment. Shanterria said that "I think my most help is my children. Understanding that I'm gonna do this and we're gonna be a family again, you know what I'm saying, that- that's my <u>biggest</u>- my *biggest* support."

Intimate partners. Women's narratives regarding intimate partners confirmed results from previous studies (Brady & Ashley, 2005; Riehman et al., 2003; Roberts &

Nishimoto, 2006) indicating that partners either helped or hindered a woman's treatment entry, depending on the partner's drug-involvement and attitudes towards substance use (Level 3 code). Miss Smart reported that her boyfriend was very health conscious and did not use any substances. She stated that he "made sure I got here [to treatment]….He's just been such a support for me….if it wasn't for him I probably wouldn't even be here." Other partners facilitated treatment entry through moral support and limit-setting. Denise described her partner of fifteen years as "a religious person" and believed that "if it weren't for him preachin', and preachin', and preachin' to me I wouldn't even be here." He also asked her to leave when she refused to stop her drug use, which she believed put her on the streets, but ultimately got her into treatment.

Women with drug-involved partners (i.e. using, dealing, or both) found that the relationship created obstacles to complying with the treatment mandate. For China, the difficulty was having her partner, on whom she was dependent, incarcerated for possession. She felt that when her partner was there "I could maintain with him even though he took me through a lot of shit I could maintain with him. I could survive" and that "if he would have been there all this shit would never have came about anyway." Penelope reported that her partner both used and distributed drugs, and that their use together had escalated during her last pregnancy and after the birth of her child. She perceived that their relationship and the treatment mandate created a profound conflict for her: "I mean I dearly love him to death, he's like- outside of drugs…perfect. Inside of drugs…no." She felt that because of CPS involvement she had to "give up someone you love because of their faults when you're not supposed to judge people by their faults" and

"that's a lot of pressure. I'm dealing with that like really bad, cause now I'm lonely I have no kids or the man I thought I was gonna spend the rest of my life with."

The Role of System Interactions

Participants reported significantly different treatment entry experiences depending on the perceived quality of their interactions with system professionals (caseworkers, probation officers, and judges), the effectiveness of the referral, and the level of professional follow-through. System interactions that women perceived as influencing treatment entry were organized under the Level 2 codes: caring and accountability, referral information, set up to fail, abuse of power, and resourcefulness (See Appendix D).

Caring and accountability. System professionals who were perceived to effectively facilitate participants' treatment entry were described as being both caring and firm in holding women accountable (Level 3 code). Descriptions of effective professionals included: caring, provided clear directions, followed through on the referral in a timely way, provided reasonable consequences for non-compliance, and was knowledgeable about local treatment options and support services (i.e. childcare and transportation). Few of the participants reported receiving this level of support.

Bobbie perceived her current probation officer to be the most helpful factor in motivating her treatment entry "because she actually takes the time to talk to me, and talk to me like I'm a person, and not just talk to me like I'm just some convict sitting in front of her". It was also important to her that the probation officer included her child: "she even allow me to bring my son inside the office cause a lot of other probation officers tell

you ‘if your kid’s with you don’t show up or you’re gonna regret it.’” Bobbie perceived that this behavior from her probation officer meant that “she really has a heart.” Yet another officer was perceived to be helpful to her by “giving me some advice to hold my head up, it’s going to be all right, stuff like that, you know he didn’t have to do that.” Tiffanie felt that her caseworker helped her with treatment entry by providing both emotional and practical support: “she said ‘I’ll help you in any way that I can.’ That was a weight lifted off my chest you know on how, you know that I had a nice person…. I’m still in contact with her. She is not my caseworker and we still talk.”

Conversely, participants who reported experience with professionals who did not hold them accountable believed that this contributed to problematic, if not dangerous, delays in treatment entry. China described her caseworker as being caring, supportive…and lenient. She acknowledged that she was “making [the caseworker] feel like, you know, I was really doing something.” She did that by “bringing in a couple of things she was asking for” such as the children’s immunization records that were required for residential treatment entry.

With no external accountability China stated that she eventually stopped making any effort at all. She reported that, although initially abstinent, as months went by without CPS enforcement of the treatment referral, her depressive symptoms became more severe. At first she stated that she used food for emotional coping, but reported that when a new male friend introduced her to cocaine and club drugs she quickly found herself addicted: “at the time I didn’t even know I was *addicted* to the powder.…Things that I cared about just didn’t really make a difference, I really didn’t give a damn anymore you

know." Looking back she wished that "somebody would have just pushed me out the damn door."

Participants who reported receiving no referral support after children were removed from their custody described the most serious consequences. Reports included escalating substance use immediately following removal of their children, and overdosing with the intention of committing suicide. When these participants were not successful in killing themselves, they chose to enter treatment. Diamond recalled that after the forcible removal of her children she was left to her own resources and "I didn't know anything. All I knew was I just wanted to die, I didn't eat nothing for- I don't know, I think it was like four weeks. I gave everything away I became a drunk, an alcoholic. I didn't care about nothing, I didn't want nothing. All I wanted to do was die. That's it." She noted that one caseworker did contact her by phone and expressed concern about her suicidality, but stated that he was removed from her case for unknown reasons.

Bobbie reported that the combination of a closed custody case, withdrawal of external monitoring, and profound social isolation led her to feel that "everybody was gone out of my world." She reported that her depression quickly escalated to suicidality: "I tried my damnedest…but I couldn't get that high, it wasn't my time to go and I tried, I'm not gonna lie to you….I spent $2100 tryin' to blow my heart up. In six days." After another arrest she was mandated to treatment by a probation officer who followed through on the treatment referral.

Referral information. Several participants reported that the information they were (or were not) given about the treatment mandate also played a role in their ability to

follow-through with treatment entry (Level 3 code). Participants defined necessary information to include: an outline of mandate requirements (type and length of treatment, expected outcomes, consequences for non-compliance), accurate contact information for treatment agencies, and an explanation of what treatment is and how they might benefit from participating.

Participants who reported having received comprehensive referral information and instructions about how to proceed with treatment entry believed that this facilitated treatment entry. Tiffanie stated that she was given "all the information" and told to "call and set up the appointment. She put that on me to do. She said you know you're responsible for this, setting up the appointment and getting it started and so that's what I did." Furthermore, her caseworker directly facilitated all aspects of her treatment entry:

> One day we spent the day just going to daycares. And then she brought me over here for my drug assessment…. she said 'I feel like a outpatient would be the best way' because she said that most of them was like Monday through Friday, and you'll have to go… pretty much all the day or six to eight hours a day, so she was like 'I will help you or take you around to show you the [public transportation system].'

Tiffanie entered treatment within a few weeks of the initial CPS intervention.

Most participants reported having received incomplete or inaccurate referral information, and indicated that this delayed treatment entry. Penelope remembered requesting a list of outpatient programs, but stated that when she began making calls from the list she discovered that her CPS caseworker had given her a list of inpatient programs

"and after I called and found out that's what was on there, I let her know she gave me the wrong list….I got a *different* list and I went down the line and I called them- well half of those were inpatient too, but [one program] was outpatient."

Some participants reported that they were simply told they had to attend treatment with no supporting information at all. With a criminal case, but no CPS involvement, Lisa remembers being left to figure it out on her own. When asked what kind of information she received from the judge after being mandated, she replied emphatically:

> NONE!! None- nothing whatsoever!! Seek treatment- [frustrated and angry] He tells me 'seek treatment.' Ok, he didn't say for how long. He didn't say what kind of treatment, or where to go to get treatment or <u>anything</u>, there was no assistance in <u>any</u> area of these, you know, requirements. If I'm <u>sick</u>, why are you leaving it up to me to handle this? I'm obviously not capable. Look at me – I'm clearly not capable of making a good decision, so why would you put the decision making in *my* lap?....at least give me the address to where the damn place is. And a token [for the bus].

Lisa went from court back to her old neighborhood where she continued to use and experience violence while she attempted to locate treatment.

No participant reported having received an explanation about the purpose or benefits of treatment in the referral process. Jasmine was referred directly to a specific program, however she recalls that "I didn't have that much information… They just gave me a paper saying about [the program] and stuff like that. They told me where to go, when to go, and how to *get to it*. That's it." However what she really wanted to know was

why she should go to treatment: “they didn’t tell me any information like this’ll help you, this will be good for you… or here’s a pamphlet on the place.” She also wanted to better informed about her children, specifically “how long is it gonna be. Where can I… you know, when can I start seeing ‘em, or, you know, just tell me something that I really…not what I need to hear, but, you know… basically, *what I need to hear.*” She believes that if she had received that type of support she “would have known that it was gonna be okay. I wouldn’t have *cried* so much.”

Set up to fail. Women described a number of ways in which they believe they were set up for failure by the system professionals who handled the treatment mandate and referral (Level 3 code). Some participants found the expectations of system professionals to be unrealistic. Upon release from jail, Lisa had multiple probation requirements including employment, substance abuse treatment, and staying out of certain neighborhoods. Although she reported being very willing to enter treatment, she was both angry and incredulous when reporting her perception of the judge’s mandate:

> Now you’re tellin' me this, and you’re lettin’ me go…. You know I have no money. And the only means I have to get any money is through doin’ something illegal….My circumstances have not changed. But you’re telling me….don’t go back to where I came from, so where do I go and where do I get those treatments? And how do I get a job if I’m in treatment and I have no place to live. You *know*! [laughing]….You understand what I’m sayin'? You’re settin’ me up. For failure.

While Shanterria reported less eagerness for treatment, she stated a willingness to comply with CPS…until her caseworker sat her down to explain the case plan:

> She was telling me about all these different programs – you know, I had to– I had to go to a outpatient program and that time she was telling me about I had to get a job and I had to be at a certain time. It was like she gave me a hundred things to do in less than two days. It was a set-up. And I told her then, 'You setting me up for failure, 'cause I can't go to treatment and at the same time look for a job and I am required to be in treatment for so many hours.'

As a result, she stated that she began to feel that her caseworker "had a personal vendetta against me" and remembered becoming defensive and treatment-avoidant.

Abuse of power. The majority of participants reported that the attitudes of system professionals played a significant role in treatment entry follow-through. This sensitivity was described as a response to the significant power these professionals were perceived to have, and sometimes abuse, in deciding the fate of participants' freedom and parental rights (Level 3 code). In many cases, the sensitivity was experienced as consuming and counter-productive to treatment entry. Diamond described how this preoccupation could spiral into hopelessness:

> … a lot of women is concerned about what people are thinking about them, 'specially judges and [CPS] workers. That is so important to us. What they are thinking you know, and that'll make us go crazy….all day when we could be doing something useful with ourselves thinking about what are they thinking about me? What steps are they taking me next? *Why* hasn't she called me? You know what I'm saying, 'I left her several messages and she's telling the courts

> that I didn't even call her, Oh my God! This is *it*. I have no *hope*,' you know what I'm saying?

Participants reported being especially attentive to whether or not they felt the CPS or CJS professional was taking a supportive or a punitive stance. Miss Smart reported that "I can get a <u>feel</u> for it….I can tell when somebody is not really out to help me" and described the typical caseworker as "quick to *judge* you and tell you the things you done wrong and make it seem like, you know – make you feel <u>*powerless*</u>."

Participants who described themselves as having assertive communication styles reported power struggles with system professionals who, they believe, expected passive compliance. Lisa said that her probation officer made it more difficult for her to follow-through with treatment entry and that:

> Somebody told me they're not used to you talking to them a certain way. They want you to be really cowering, and humble, and really scary, and I- I'm more of a straight-forward kind of person: 'am I meeting the requirements? Yes or no?'….I'm an adult, you know, you're not going to talk to me as if I'm an idiot….you shouldn't need that to feel like you're somebody. You have a job, you know?!

Several participants reported the perception that they were being personally targeted (i.e. the system professional didn't like the participant for some reason and took it out on her through interfering with the treatment mandate). Participants consistently identified these interactions as stressful and detrimental to treatment entry. As Tre described: "sometimes they might do things- they might really have a personal vendetta

against *you* and they using the *kids*. You know what I'm saying?!? And that's- sometimes that's how I feel." When asked how this made her feel, she responded "I wanted another *rock*!! [laughing]."

Nicole stated that she initially wanted to go to outpatient treatment, but that her caseworker favored residential. She believed that the caseworker intentionally delayed referring documents to force Nicole into another program: "I couldn't start [the outpatient program] without the referral….It was like two weeks later when they came out to the house. The referral still wasn't there. So I think she just didn't want me to go to outpatient period." The delay in follow-through lasted several months during which time Nicole reported thinking "if I was such a risk why did they take so long [several months] to come to the house? I hadn't heard from them or anything. So I'm figuring well you know I guess they're not comin'." She reported resuming her marijuana use and, after a particularly bad day remembered resorting to cocaine use and quickly becoming addicted.

Diamond also believed that her caseworker "was literally trying to do stuff to deliberately hurt me" (which in her case was confirmed by another caseworker). She described the futility of trying to advocate for herself:

> I been trying to tell 'em, it's you! You scare me! Leave me alone! [laughs] I don't wanta be here. And they're pointing their finger at you '*you're* the problem, you're the biggest problem, and you need to do this, you don't need to be doing…' No! What you're doing is *scaring* me. [laughs] You know. Shooot.

Resourcefulness. In the absence of a supportive and fully informed referral, participants described several resources that helped them find their way into treatment

(Level 3 code). Miss Smart recalled that it was a personal connection that finally helped her locate a program: "I was going to www.rehabilitationcenter.com and all that stuff and I couldn't find one….that was suitable for me." She stated that she finally found a women's residential program through a friend's cousin who gave her a personal referral and put her in touch with the clinical director.

Participants without financial and social resources reported considerable difficulty finding and accessing treatment even if they were highly motivated. Lisa, homeless, with no local family or friends, and no income, described trying to contact an outpatient program she had previously attended in the hope that they could facilitate access to residential treatment: "They were not at all helpful. They gave me the address to [a homeless shelter that works with addicts] and would not even give me a token to get there. I had to walk. So how helpful is that. And they're a treatment facility." She reported that the facility did give her a list of shelters to call which, as she put it "is not helpful if you have no money and you can't make phone calls….Okay. People with no money don't make phone calls. They don't have cell phones, they can't get anywhere because they have no car fare."

Lisa described a period of trial and error, until a chance encounter on the street led to treatment. She, along with Denise (recently homeless, no local family), recalled being approached by street outreach workers who facilitated access to medical care and substance abuse treatment. Lisa noted that, after getting a business card from the outreach workers, it took several days to reach the shelter by phone and then a visit to the health department for contagious disease testing before she was admitted. Denise, who had

taken care of medical requirements trying to get into another program, was able to enter treatment the same day: "I was standing in the rain and they pulled up and asked me did I want to go into treatment and I left with them that day." Asked if she felt luck played a role in her treatment entry she replied in a whisper, "oh yeah. Oh yeah. Yeah. [normal voice] I- I *prayed*." Once in, she recalled that the shelter staff facilitated contact with her probation officer and subsequent treatment entry: "they were very instrumental in calling my probation officer, setting up an appointment, explaining my circumstances, and- and- lettin' them know that….I really wanted to get my situation back on deck, you know, get- get right with them."

Participants also reported receiving help locating treatment through chance encounters with other women in the courtroom and in jail. Diamond said that she was in court waiting on a hearing when she overheard other women talking about their outpatient treatment program. She remembered that "they were just sitting on the bench talking about it and 'Well I go to [name of program]. *Girl*, they got me clean off drugs and I feel good and you know they helping me get my kids back!' and I was like 'wow! Okay!'" Tinori recalled that she found out about treatment from a cellmate: "I seen her with one of the books that she got from the law lib'ary…. and it had all different types of rehab and I said 'what is that?'" She learned a little more from fellow inmates: "I heard about people that was getting locked up….the judge was *sendin'* them [to treatment] to get help so that's what I asked for and that's how I found out about rehabs."

Finally, women who perceived their referring professional to be abusive or neglectful reported seeking help from an unlikely place: drug court. Several participants

reported that they enrolled themselves in drug court as a form of protection because they found that judges would hold caseworkers accountable for following the treatment plan, providing supportive services, and communicating with their clients. When asked how she found treatment Jasmine explained that "drug court showed me how to do it. They said they were gonna send me to a place, um, called [residential program]. They told me [that program] would be *good for me*. I said all right well I'll go."

The Role of Child Custody

Participants' descriptions of the relationship between child custody issues and treatment entry were captured in one Level 2 code (Appendix D). Many participants perceived their children as being vital to their sense of purpose, identity, and motivation. Nevertheless, many mothers in the study reported that the cumulative effects of a lifetime of abuse, ongoing mental health issues, and substance abuse severity, combined with despair over system involvement, and the threat or actual removal of children, proved difficult obstacles to overcome. Tre articulated her feeling of being caught between her addiction, her love for her children, and CPS involvement:

> It's just how- how- you know what I'm saying [tearful] it's just how much I love my kids. But not thinking, if I really *loved* them I wouldn't be running with them, you know what I'm saying, putting them in harm's way, and from hotel to hotel I'm still getting high. Still tryin' to keep my kids [tearful]….And then to know I was more so hurting them than tryin' to love em. [crying, sighs] And maybe I *thought* I was being a good mother when maybe it was the drug that had me feeling that way.

Participants in this study reported that custody sanctions can be a motivating force, however women perceived that it may just as easily cause delays in or avoidance of treatment entry. Custody sanctions also were perceived as causing significant emotional and physical harm to participants, their children, and their extended family. Participants described a complex set of variables that had an impact on their response to child custody consequences and their motivation to enter treatment. These included whether they retained or lost custody, losing hope, and perceptions of child placements.

Retaining custody. Some participants reported that they were allowed to retain custody of children on the condition that they comply with probation or case plan requirements (Level 3 code). Based on analysis of participant narratives, there were no consistent predictors to indicate whether this approach would be effective or not. Tiffanie, who reported being equally scared of CPS and her boyfriend, perceived the threat of custody sanctions to be highly motivating. She remembers that her boyfriend was outraged that she put his children at risk by using during her pregnancy and that the caseworker told her "I don't mind taking somebody's kid and you know putting them into foster care if I feel like it makes it better for them." Tiffanie remembered that she was "scared to death" and that she "told [the caseworker] right away, I will comply with everything you want me to do just keep my kids with me, cause that my…that's my heart right there."

Others in the study who were initially allowed to retain custody of children reported being either less interested or less able to follow through on their agreement to enter treatment. Jasmine recalled that she "just did what they asked me to do, you know,

for that particular time so that my baby could come home" and then "went back and started using and I kept using until they took my kids." She stated that "they gave me time to get into inpatient treatment. I did not go. I did not go at first, I fought it off for like a month" until "all of my kids end up gettin' taken for at least about six months." Tre also remembered being given a chance to enter treatment on her own. She reported that in the hospital (after giving birth) and during initial caseworker visits she agreed to comply with all requirements, however once she was allowed to bring her infant home she "went back to doing the same thing. I went back to old *playground*…where I got my drugs from."

Referring women with custody cases to residential treatment also appeared to yield mixed results. China recalled that when she was referred to residential after failing to comply with an outpatient referral "it just sounded so gravy you know, I can have my *kids* with me I don't have to *worry* about what they doing….I mean I was really excited at that time." Miss Smart believed that "if they would have took the baby and said as soon as you get into treatment you can have your baby back wit'you, that would have helped me. I would have got in sooner."

On the other hand, Nicole remembered being unhappy that her caseworker was requiring a residential program for women and children, and that she was being asked to remove her daughter from her mother's home and bring her to the program. She perceived that "not only is it hindering us, but it's actually- you're forcing this child to leave from where this child *knows* to go somewhere that they <u>don't</u> know." She stated that she initially refused to enter treatment "because you're not lookin' at the feelings of

the child, you know, you're just based on lookin' at well what I want you to do." She complied when told she had to enroll with her child or lose custody.

Losing custody. Removing children from maternal custody was perceived to be an especially unpredictable influence on treatment entry (Level 3 code). Tracey hoped that CPS "might realize one day it's a double-edged sword." When asked to describe the two edges of the sword she replied that:

> One [edge] is well…. they tellin' me to go so I'm gonna go on and go. The second is that- you done took what I had to live for, you know? So my kids are my life so the hell with it, you know. It's like you dangling a piece of food in front of a- a piece of meat in front of a wild dog, you know what I'm sayin', but you snatched it away, and throwin' it away, you know? So where is he gonna go, he gonna go chase that- that piece of meat and I might've throw it out in the middle of the highway, you know, and he gonna get hit tryin' to get it.

Penelope recalled that having her children taken was "like- my world was destroyed." She remembered feeling torn between turning her children over as requested and running: "I just wanted to get my kids and go to [another town], or go somewhere, you know, I didn't want their help anymore, cause- like- this situation is like the worst thing that's *ever* happened to me." She stated a belief that she would have complied if CPS had allowed her to keep her children. However, later in the interview she reflected, "who's to say if I would've had 'em I still probably would've been trying to scam, or plot my way around" because "I would've had em so it wouldn't have been a big deal for me." She believed that she would have tried to comply but that "it really took them

getting *took*" because "with them *gone*, it's just not a chance to fail. You don't have that opportunity to fail."

No hope. Individual resiliency in the face of child removal was a pivotal factor in whether women complied with the treatment mandate. Many participants reported that the initial removal of their children caused a profound sense of despair and hopelessness (Level 3 code). Tracey believed that having her children taken was "what took me so long before I came to treatment. I was like: you got my *babies*. Shit, what else you want from me? You can't get nothin' else, I don't care no more. I just gave *up*." Failing to comply with treatment entry was not the only outcome; women reported that losing their children, even as a temporary consequence, led to escalated risk behaviors and, in some cases, to suicide attempts. Jasmine recalls that her children were taken directly from school with no notification to the family and that her mother was "knocked to the ground" in the process of removing her infant:

> My memory of it was like no hope….*I wanted to drink myself to death.* I really felt like it wasn't nothing else I could do. Like wasn't nothing else to live for, you know. To go and to see that your house don't have kids, you know, hollering or playing. Or no, it's just quiet. So quiet you can hear the crack in the wood floor. You can just hear it. You know, you can hear every crack. But it was….torture. Torture.

Jasmine reported entering a period of escalating drug use, but that she eventually realized "I gotta do what these people tell me to do. If it… if it was anyway other way around that… I woulda been testing my water, I woulda still been playing. So now, I'm

not playing anymore." Although initially angry at her caseworker, she now believes "the system works….*because* if they woulda never took my kids I would have never wanted to be clean" and that by removing her children they "brought something outta me that I didn't know I had and that was *willpower*."

Shanterria believed that it took the threat of permanent custody loss to finally motivate her to enter treatment. She recalled that the high stakes led her to ask for placement in residential treatment directly from jail: "I said um 'because if I go out I might well be-….you know if I couldn't be with them, and I couldn't get to them, then I knew if I went back out then, at that time- I was gonna OD." She reported that she received her request however she was soon discharged for breaking a program rule and subsequently attempted to overdose. She survived but stated that she did not enter treatment again until she received a call from her youngest son telling her that he was about to be put up for adoption:

> He said 'momma if you don't go to rehab they fixin' to put us up for adoption' and I said '[son] I be in rehab at the end of the month….I'ma go to court and if I go to jail from court that's be fine, from jail I go straight into rehab,' and that's what I did. I came on in.

Perceptions of child placements. Women's responsiveness to child removal as a treatment entry motivator was influenced by individual attitudes towards the custody placement, perceptions of foster care, and CPS implementation (Level 3 code). Participants reported mixed responses to placing children with extended family members. For some, knowing that children were safe with family, intimate partners, or friends was

seen as an excuse to continue using. Tre said that her mother was "afraid if she get 'em would she be stuck *wit* 'em?" because "a lot of times, honestly, when my family had my kids, okay it was time to party. Because I knew my children was taken care of. Cause they better to be with family *than to be with strangers."* Mary said that her mother reported her to CPS instead of taking her son to live with family specifically for this reason. As Mary recalled:

> …she felt like if she would have took him on home with her, then that would have given me more reason to continue to use….'well he at home with mom, I ain't got nothin' to worry about, I can go get high party all I want to.'

Other participants felt they could not put their attention towards treatment compliance until they knew their child was safe with family. Vee recalled that she told her caseworker she was "willing to do whatever she said, just make sure he's safe at my momma house." She said that she needed to know her infant "would be loved. The family was gonna take him in." Once her child was situated with her mother she reported taking the necessary steps to enter treatment.

Underlying these attitudes towards child placement was a pervasive and profound fear of foster care. Participants reported that their fear was grounded both in current and historical events. Vee explained that she pleaded with her caseworker for family placement because of "all the *stories* I heard about foster care. All the- *neglect*, rapes, abuse- because people just want the money and a lot of people who been in foster care, that's where most of the abuse *happened*." Penelope explained that part of her despair at having her children removed was that "kids in [local CPS] custody have died, [crying]

you know what I'm saying, if something happens to my baby in a foster home, you know, I cannot replace my child, my child is ir-re-placeable."

Several participants, especially those who reported binging or attempted overdosing following a child removal, expressed a fatalistic sense of powerlessness when children were placed in foster care. One participant tied custody sanctions to systemic oppression and the legacy of slavery. When asked how race impacted her overall experience with mandated treatment, China responded that "I hear a lot of Black women talking about we're still in slavery" because:

> All *you* do is have the baby, but the baby is automatically the government's you know, they tell you what- when to put the baby in school you know, if you get in some kind of trouble they *already* look at the baby as theirs so once they snatch your child up they gonna try to keep your child, sign 'em off and, I mean 'who wants this baby?' just like they used to back in the days: *auction* your baby off, you know [harsher tone] that's what they call '*adoption'* these days.

Treatment-Specific Factors

Although participant narratives primarily focused on individual, social, and systemic influences on treatment entry, they did discuss several issues specific to substance abuse treatment (Level 2 code; see Appendix D). This data was grouped into sub-themes (Level 3 codes) describing participants' expectations of treatment, prior experience with treatment, and housing concerns.

Expectations. Expectations of treatment from participants with no prior treatment experience were captured in this Level 3 code. Very few of the participants had any

accurate knowledge of treatment prior to their first admission, if they had any knowledge at all. Throughout the interviews it became clear that this lack of knowledge contributed to erroneous expectations of treatment and related delays in treatment entry. Tinori remembered that she "really had no idea what a rehab was or [laughs] that it was such a thing….I didn't know- I knew there was places that you can go and get *food*, shelters and stuff like that but I didn't know nothing about [substance abuse treatment]."

Without prior knowledge of treatment, women had no idea what they were being referred *to*. Several participants remembered that all they knew about treatment at the time of referral was that it was "just something that you get out of jail from trying you know" (Tinori) or that "it was just gonna…help me get my kids" (Diamond). Hearsay did not prove to be especially accurate. China reported that her best friend, "a recovering crack addict," told her that she would "hear other women's stories about what they went through and you know she was like some of 'em be funny. It was more of a laughing matter" so China had "*actually* started looking forward to it." Shanterria said that treatment was "*nothing* like I expected- well actually I don't know- I didn't know what I expected it to be."

With no information to go on, participants often projected their experiences with caseworkers and probation officers onto treatment professionals. Diamond said that she expected counselors were "gonna be like judgmental people," and Miss Smart stated that "I just thought everybody would be mean and tough on you." Another expectation was based on negative stereotypes of and experiences with both addicts and convicts. Tre was one of several women mandated to residential treatment who expected it to be "like jail.

It's- it's the next thing to *jail*. You got someone over you telling you what to do, how to do it, *when* to do it, you know what I'm saying and that's like *jail* to me." Penelope remembers thinking that she "wasn't too keen having a whole bunch of women I don't know, especially as drug addicts who- probably steal my stuff and- who *knows*, just like I would not be able to be in prison with a lot of crazy convicts, that's why I chose drug court as my relapse prevention program, cause I refuse to be in jail."

Among participants initially referred to a gender-specific program, several had negative expectations of being among other women. As described by Nicole, "I did not like the fact of being around a lot of *females*. I guess it might be because I grew up with jus' bein' around my [male] cousins like that, but I just- that's never been me." She further explained that "you got some females out there that's real *trifling*, and from some of the stuff I've seen females *do* you know and I'm jus like, never was the type to deal with a group of females." Tracey had a similar concern in that "I deal with females a little bit, but I don't like to be around a lot of the same- us- because it be too much *chaos*! [laughs]."

Finally, women referred to residential treatment were concerned about loss of independence and privacy. Penelope noted that "I had never been in a treatment center so I didn't know what to expect, but I knew I didn't want to live with strangers." Tracey pictured it "like a dorm or something like that, and everybody piled in together, and Tre was worried about "the different personalities that conflict." Tracey expected that treatment would consist of "people asking you any and everything about your life. Or

about your *biz*-ness. Yeah- wanta know every detail of your bizness, life or whatever you know."

Prior experience. Women with prior treatment enrollments had more realistic expectations, however this was not predictive, either positively or negatively, of women's willingness to enter treatment (Level 3 code).Participants reporting multiple treatment entries stated that they used treatment as a respite when life on the streets became challenging. These women reported readily entering treatment whether voluntary or mandated. Vee stated that "I've probably been in thirty, forty treatment centers. Because I've been too scared to stay out there….I mean when stuff got *too hard*, I'd run to treatment. Cause I'm just- I've never been homeless."

Another participant, Renaii, reported being in and out of treatment since adolescence and stated that she would seek out treatment when she needed "a roof. That's my main thing." Further incentive was "to have fun, cuz you did have a lot of fun in recovery. Go on trips go to the beach. Stuff like that. They have a lot of events. NA dances, AA dances."However she was clear about the limits of her participation saying that she "knew how to play [the system]. [laughing] I knew how to get around." Denise reported that having attended treatment (unsuccessfully) as a young adult, gave her knowledge of treatment that facilitated her current entry, twenty years later: "the more I went into treatment, I find a lot of help is out there. You just gotta ask, and….the years I've been in and out of program and shelters, I'm like yeah, this would be worth it."

Participants also reported that prior treatment experience contributed to delays in treatment entry. Mary stated that she was reluctant to comply with the treatment mandate

because, while she had successfully completed treatment years ago, she perceived her addiction to be more severe and said that she was afraid of failure and losing permanent custody of her child: “this time I thought I couldn’t do it, I mean I was just that hooked on drug, I couldn’t believe I could do it. [Silence]…. I knew I *had* to in order to get my son.”

Others who knew what to expect of group and individual counseling, reported being afraid to go back and face the issues underlying their substance use. Denise remembered that in treatment “you just sit in groups and hear…people admitting to their problems. And that was scary to me.” Tre said that women she knew on the street were treatment-avoidant because “something’s really happened to these women that they don’t really- they’re not ready to face yet.” When Tinori was asked about her first encounter with treatment, she remembered thinking of the process groups:

> How could you just- how could you *tell* people ….I mean it- its okay saying ‘oh yeah I did this and I did that’ but- not being <u>raped</u>. 'Cause to me being raped- I was embarrassed. By selling my body I was embarrassed. You know what I’m saying? I looked at myself like I was- I looked *down* at myself so why- ?.... they just talking it about it like it ain’t nothing. And it *hurts* when I talk about it. When I used to talk about- I mean when I used to think about it and stuff I mean it <u>hurted</u>. So why would I-? I didn’t want to tell nobody. Unt-uh.

Prior experience or not, participants understood that entering treatment meant some type of change in their lives. Their readiness for change of any kind either facilitated or hindered entry. Tre believed that for many women “the biggest fear is

change." Of herself she said, "I was *scared*. You know your main fear be failure: will I do it this time? Will I get it this time?....I asked back then 'man, I wonder if I really tried would it be that bad? To change?'"

Housing. Housing concerns were perceived as a tipping point for many of the participants, either as a motivator or a barrier (Level 3 code). Women who were having difficulty with basic needs reported greater readiness to enter residential treatment. Tinori, who entered treatment directly from jail, said of residential treatment that "I didn't know nothing about a serenity prayer, I didn't know nothing- …. I had no idea….So I just felt like oh well take that opportunity you gone be in your *own* apartment and everything you know [snaps her fingers]." Lisa reported that her housing needs were a primary motivator towards treatment entry: "I knew I needed to get off of that <u>mat</u> that I was sleeping on [at a homeless shelter], I needed a place to live, I needed some stability." When she was offered access to treatment through a faith-based women's shelter she remembered thinking, "well, I'm not particularly religious or anything, but- huh!- a little Jesus certainly can't hurt right now, you know! [laughing]….and it was safe, you know, and I- I felt like I needed that, you know, so um...and I did."

On the other hand, women who perceived themselves to have stable housing and some form of reliable income, and who were referred to residential treatment, reported being highly resistant to treatment entry. Tracey was mandated to residential and refused "because I was not gon' give up my apartment, and leave my car and have to go away." She reported that what finally forced her hand was a caseworker who got a court order with an ultimatum: residential treatment or permanent loss of custody. She remembered

that "boyee, when I came out that court I wanted to hurt the world.…but kicking and screaming, I went. That was a Thursday, I went Monday. And I went into a residential program."

Participants who were experiencing stability of basic needs perceived a referral to residential treatment as a threat to the stability they had created for themselves and their children. Penelope remembered her disbelief when receiving her treatment referral (note that, with no prior treatment experience, she also equated residential treatment with homeless shelters):

> You're gonna take me from my *house* that I've built and I've put together to put me in a shelter and you're telling me you're gonna give my kids back, so if I'm homeless I can get my kids, but if I do drugs I can't?!? Stuff like that don't even make sense- is not even realistic to me, the things that [CPS] say that work there….is crazy.

Tiffanie was one of a very few participants who were given a choice between residential and outpatient treatment. She reported being willing to do whatever she had to in order to retain custody of her children, however she also remembered that "I was thinking while she's saying that [about residential treatment], I want the outpatient you know cause I don't really want to leave my comfortable home to go live some place….I was just hoping they wasn't going make me go to a inpatient."

Telling Our Story

Early in data collection it became clear that the interview itself was a significant experience for participants. Consequently the protocol was expanded to ask women about

their reasons for participating and their experience with the interview process (Level 1 code; see Appendix D). Two sub-themes (Level 2 codes) were identified in participants' reported interview experiences: wanting their individual stories to be heard, and experiencing a sense of relief after telling their stories.

Wanting to be Heard

Almost all of the participants reported that they volunteered to be interviewed because they wanted their experiences with mandated treatment to be heard (Level 2 code; see Appendix D). Tiffanie explained that "nobody ever asked our…point of view of the whole situation, how we feel about having to come, about being mandated to come" and believed that part of the problem was stigma because "it's not always that people wanna hear what we have to say because we're addicts." For the most part, participants were asking that their basic human feelings be recognized. Tinori wanted "my opinion to be *recognized* and that somebody will *see*, and understand and <u>feel</u> and take into consideration how I feel or how *people* feel, period, about certain things."

Participants reported feeling most unheard by system professionals who were in charge of their referrals. Nicole described trying to explain to her caseworker "how I *felt* about the situation and you know like I told her if you're not happy with something you're not gonna do your best at it." She felt that "regardless of how I tried to tell her it was like 'I don't care. This is what you're gonna do, if you don't do it I'm gonna take your child.'" Nicole's desire to be heard by an individual caseworker was echoed in Tinori's hope that system professionals become more aware of the impact of the mandate itself:

> The *judge* need to read it [her interview]. [laughing] The- *all of em* need to read that story cause…[serious] they really need to know….because they affecting people's *lives*. They messing with people. They- they got 'em goin' through so *much* that they really don't know what they got the person goin' through. You don't know what- they don't know how they *affecting* somebody else's life. By trying to mandate.

For many of the women helping others was a key reason for participating, as Tinori said "I really jus' hope later on down the line it's gonna help somebody. Period." Diamond, referring to perceived negative attitudes and prejudice among some caseworkers, hoped that her story would invite greater sensitivity in the treatment mandate process: "people have no idea and some of their actions and the things that they say, and comments they make it actually- they don't know it hurts them." She believed that becoming more aware would increase understanding of "how to go about helping us and what steps they should take." Tracey also hoped that her story could "be some *insight*" and that maybe for other women "things don't have to get as far as they did *with me*. Could be arrested *sooner*, you know, than later. That's mostly my main thing about it."

Participants reported that it was important for them to feel heard by somebody who cared. Nicole said that she did the interview because "I wanted somebody that actually *cared* to hear what we had to say, or hear what I had to say," and Tiffanie reported that the interview was helpful because "somebody actually cares what we have to say, it seems like sometimes they don't really care." For Miss Smart, it was important

to have fresh ears: "I can sit and tell my...fiancé about it, I can tell him about it all day, but for me to tell somebody that I *didn't* know is better."

Relieved of a Burden

Another significant finding was the experienced therapeutic value of the interview itself (Level 2 code: see Appendix D). Every participant reported benefitting in some way from exploring their experiences related to mandated treatment. Penelope, one of the first participants to be interviewed, described her experience as "therapeutic at the same time as informational." Participants connected their positive experience in the interview with having felt judged, stigmatized, and unheard by system professionals. Miss Smart described relief at being able to talk about negative attitudes she experienced from caseworkers: "because of my past case. Like 'she ain't gonna never get it together', that's how I think they view me." As a result of completing the interview she reported that "I feel like a barrier has been lifted. I feel like something has been lifted off my shoulders. That's just how I was feeling."

Participants specified the importance of knowing that their stories would be used to educate professionals. Diamond described the burden of carrying her problems related to the treatment mandate, and the freedom she experienced from being heard and knowing her story would be shared:

> I feel happier inside that someone knows and is gonna share with the world how women really feel, how some women really feel inside. I feel good. I feel like I can move on….Cause when you have things on your shoulder like that you're *stuck*. You feel stuck because it's almost like it's a ton of bricks on your back and

> you like 'why I can't stop thinking about all these problems I'm going through?' and all these issues have gone on that's not being *met* and no one *cares*, you know and then it makes you feel good that someone cares and you can put that behind you and go on free. [Energetically] 'Oh God I'm free! Oh I'm free, I'm not tied down to this!'….That feels so *good*!

Advice to Counselors

Women reported either positive or neutral experiences with intake and assessment counselors. Nevertheless, they had a number of suggestions about how treatment programs and counselors could improve effectiveness in bringing women into treatment (Level 1 code; see Appendix D). Identified sub-themes included advice for establishing therapeutic relationships, the importance of supporting internal motivation and of addressing shame (Level 2 codes).

Establishing Relationship

All participants indicated a desire for supportive relationship, particularly those who had become isolated from friends and family and those who felt stigmatized, ashamed, and socially marginalized because of their substance use. Participants identified ways that counselors could approach them that would help with establishing rapport and thereby facilitate treatment entry (Level 2 code; see Appendix D).

Respect. Participants wanted counselors to know that they perceived respect to be a foundational condition for relationship building (Level 3 code). Tiffanie explained that if counselors approached women "just thinking bad right off the rip….people put up their defenses and they give it back to you," and that to establish relationship counselors

should “treat people respectfully, just like I was always taught when I was young. You give respect you’ll get respect.” More specifically, participants stated a desire to be seen as a whole person. Tre asked counselors to keep in mind that “we were mothers before we were *addicts,* and don’t keep lookin’ at me as a addict. I’m still a *mother*. I’m still someone’s sister. I’m still someone’s *daughter*, you know what I’m saying. You know, I’m *human*.”

Trust. Participants also discussed the importance of trust in building therapeutic relationship (Level 3 code). One example came from Tiffanie who remembered how important it was for her during the intake process to hear about confidentiality and the boundaries between treatment and CPS: “the best thing was letting me know anything you say to me will not be told to your caseworker it’s between me and you.” She explained that knowing that right away “ helps you to ease your mind” and that “everybody’s not gonna trust right away anyway, most people is not going to, but they did a really good job of breaking my wall down that I built up to get them to talk to me.”

Get to know us. Women felt it was important for counselors to know them as individuals and not only as addicts (Level 3 code). They emphasized not judging women by their history because, as Tre put it: “it may take- it may take me falling down ten times, or fifteen to twenty-five times for me to just really, really get it right.” One metaphor came up repeatedly:

> Never judge a book by its cover. Read the book first and *then* you decide the outcome afterwards….because you never know what that person is really going through deep down, you never know what’s goin' on at that person’s household,

> or whether or not that person is being mistreated or whether that person is feeling unwanted or unloved or anything. (Miss Smart)

Women wanted counselors to be able to distinguish between past behavior and future possibilities, as Tre commented: "we all have made mistakes in our lives. Don't keep lookin at me to be this god-awful person when there is a possibility- if *God* can forgive me and change me, you can forgive me and give me a chance." Tiffanie wanted counselors to give women "a chance to explain and tell you, hopefully they'll be honest with you, but give them a chance to know that person. They might not be- they might not be that bad of a person if you just get to know them."

Be encouraging. Participants suggested that counselors be encouraging with women entering treatment (Level 3 code), particularly given the punitive and threatening attitudes they often experienced with referring system professionals. Miss Smart suggested that counselors "speak encouraging words, that would be my opinion. Encourage. Be encouraging." Diamond felt that counselors could be more effective inviting women into treatment by saying "'I think you need help 'cause I think you're a good person. You could be doing this and that, what would you like to be doing? How could we help you do it? Let's go we'll do this together,'" She explained that if she were entering treatment and heard that "I'm going to appreciate that this person is concerned about me and my children."

Supporting Internal Motivation

Another consistent recommendation that participants had for counselors was to help women identify internal motivators (Level 2 code; see Appendix D). Women

recommended that counselors help women understand that treatment was for them, and that they could establish personal goals beyond complying with the mandate. Tinori told counselors to be very direct, even firm in asking women "what do you want for yourself?" because "people that still sick-and-suffering, *still* they do want something for theyself. Regardless if they *high* or whatever, they *want* something. For theyself. Trust me. I *know*." Mary suggested that counselors extend an invitation to women entering treatment: "have you ever just really took time to get to know yourself?…To learn about you and what you really want out of life? Not just living life day by day….Just take time out [to think about] yourself and your family."

Several participants believed that counselors would be more effective bringing women into treatment if they educated women about services and emphasized benefits that would appeal to individual concerns and hopes (Level 3 code). When asked to describe benefits of treatment that would have motivated their treatment entry, very few participants referred to substance abuse-specific intervention. For Denise the most attractive benefits were family counseling, employment assistance, and improved self-esteem: "*Family*. Yeah, cause God is big on restoring families. Yes, yes. And um, jobs and…[voice softens, quiet] my dignity. And that is such a good thing." Although that was not information she received before entering treatment, she believes "that would've made a difference" as opposed to only being told negative consequences.

Diamond recommended that counselors give women "good *reasons* why it will change they life. And how it will change they life." In particular, she stated that she would have liked to know how other women benefitted in their own words. She thought it

would be helpful if she had received a "little brochure stating things that has happened 'well such-and-such woman this is changing her life,'" and that if she had been able to learn what other women gained from treatment: "you never know one of these things could be like 'wow this is what I really wanta change, I'm going!'"

Addressing Shame

Many of the participants identified shame as a barrier to treatment, and believed that support and understanding would have facilitated their treatment entry (Level 2 code; see Appendix D). Participants pointed out that CPS and the CJS rarely seemed to consider the underlying issues that led to their substance use and related risk behaviors (i.e. drug possession and distribution, prostitution, child neglect). They felt that this was a significant mistake on the part of both referring professionals and of treatment counselors. Miss Smart suggested that intervening professionals "need to try and get to the root of the problem: why [women are] using, to see if anything they say, or do, can help the person *want* to get into treatment." She explained that one underlying issue is that "some women think that they aren't good for nothing, you know that they'll always be a- a black sheep."

Vee recommended that counselors should expect that "we're manipulative," but understand that "a lot of times we're scared on the inside because we've had so much stuff out there that we've done, we don't even know how to treat ourselves with respect and dignity….we have a lot of shame and guilt." Jasmine believed that her treatment intake and assessment experience helped her move out of the shame of being an addict and into the program:

> They made me feel*, don't be ashamed*, you know, it's others just like you. Or even worse… or just beginning, you know….They let me know ain't nobody got to just really be out there. You ain't got to be out there unless you want to be out there….They was on point. They made me see myself for what it was. For what I was.

Discussion

This study explored African American women's perceptions of mandated treatment and the implications for treatment entry. For the most part participants perceived mandated treatment to be helpful, conditional on individual treatment readiness and the way in which the mandate was implemented. This finding is consistent with literature regarding the role of individual perceptions in mandated treatment motivation (Klag, O'Callaghan, & Creed, 2005; Marlowe et al., 2001),

Participants identified several factors they perceived or experienced as facilitating mandated treatment entry. These factors included: internal motivation, having choices, treatment-affirming social support, positive attitudes towards treatment participation, and interactions with caring system professionals who provided timely referral assistance and enforcement. Participants who reported having experienced a combination of these factors expressed more positive attitudes towards the treatment mandate and were more likely to comply. The absence of one or all of these factors was perceived as contributing to treatment avoidance, delayed treatment entry, and in several cases participants felt they were put at risk for escalating substance use and suicidality.

These perceptions are consistent with the idea of layered and interactional pressure as found in Marlowe at al (2001). Participants confirmed findings from earlier studies indicating drug-involved family and intimate partners as barriers to help-seeking behavior and, in the case of this study, to mandated treatment entry (Brady & Ashley, 2005; Riehman, Iguchi, Zeller, & Morral, 2003; Roberts & Nishimoto, 2006). Results of this study also confirmed that family members, intimate partners, and children contribute to pressure to enter treatment as found in Marlowe et al. (2001).

Although evidence has been found of racial bias in CPS and CJS policy enforcement (Chibnall at al, 2003; Coyle, n.d.; Kansal, 2005; Zerai, 2002), most participants did not report perceptions of institutional racism (i.e. one racial/ethnic group consistently being treated differently than another). Participants who denied the existence of institutional racism noted that they had interacted either primarily or exclusively with African American system professionals and that they perceived no difference in sentencing by race, ethnicity, or gender (although they did perceive differences by SES and parenting role).

All but one participant reported having observed and experienced class bias at both the institutional and individual level. Participants distinguished poverty, or being *perceived* as poor, as the primary factor contributing to systemic discrimination in the use of mandated treatment and custody sanctions. The influence of pervasive stereotypes of poor, Black, women (i.e. ‘welfare mothers’, ‘crack whores’) was perceived as contributing to prejudicial actions and attitudes on the part of some system professionals. The literature confirms that individuals marginalized by multiple oppressions (i.e. race,

gender, and class) are at greater risk for punitive institutional intervention and systemic neglect (Beatty, 2003; Burke, 2002; James et al., 2003).

Threatened external sanctions for non-compliance (i.e. incarceration, loss of child custody) were perceived to have some impact on treatment entry motivation, as indicated in the literature (Ehrmin, 2001; Gregoire & Burke, 2003). However, participants indicated that any motivation they experienced related to external sanctions was facilitated or negated by other factors (i.e. intrapersonal, family, intimate partners, economic, legal, medical). This finding is consistent with existing literature on African Americans and barriers to mandated treatment entry and engagement (Rapp, Siegal, & DeLiberty, 2003; Riehman et al., 2003; Roberts & Nishimoto, 2006).

Participants provided valuable new insights into the efficacy of custody sanctions as a means of coercing treatment entry. Findings both supported and contradicted literature regarding the efficacy of child custody as a means of motivating African American women to enter treatment (Ehrmin, 2001). Several participants openly admitted that they did not take the treatment mandate seriously until their children were removed from their custody. However, women with high substance abuse severity and/or low social support reported that removing their children initially decreased their motivation to enter treatment. This was especially true of participants who drew parallels between CPS intervention and slavery and thus doubted that children would be returned whether or not they complied.

The role of child placement in treatment entry motivation was another new finding. Previous studies have found that custody sanctions may motivate treatment

entry, but that these effects fall off over time (Rittner & Dozier, 2000; Scott-Lennox et al., 2000). Findings from this study shed light on possible reasons for these variations in the efficacy of custody sanctions with substance abusing African American women. One finding was that participants indicated differential responses to children being placed with family members; knowing that children were safe with family was either motivation to enter treatment or provided an excuse to continue using.

Another new finding was that many participants believed that local foster care placements put children at risk for child abuse and neglect and expressed considerable fear at the thought of their own children being placed in foster care. Women reported that their fear of foster care placements either increased motivation or distracted them from treatment entry follow-through as they focused on getting their children to a safe place.

Where earlier studies found that substance-abusing African American women reported shame and guilt related to parenting deficits as a barrier to treatment entry (Ehrmin, 2001; Finkelstein, 1994), most participants in this study reported satisfaction with their parenting. It is possible however, that participant perceptions of parenting will shift with additional time in treatment. Those who did report shame and guilt as a barrier to treatment entry were concerned about having to reveal histories of being sexually abused, as well as having engaged in prostitution. An additional insight was that some participants delayed treatment entry for fear of failing, both because of earlier periods of successful abstinence and because of the threatened consequences for non-compliance. Contrary to previous studies (Allen,1995; Ehrmin, 2002; MacMaster, 2005; Roberts,

1999) participants did not identify fear of relinquishing substance use (as a coping mechanism) as a treatment entry barrier.

As pertains to systemic issues, participants spoke at length about their experiences with CPS and CJS professionals and the ways in which these interactions facilitated, delayed, or prevented treatment entry. While existing literature identifies inadequate assessment and referral as barriers to mandated treatment (Dakof, et al., 2003; Metsch & Pollack, 2005), it does not reference the role of client-caseworker interactions. In this study several participants reported significant difficulty with some CPS and CJS system professionals who were perceived as intentionally blocking or sabotaging their ability to comply with mandated treatment referral.

Ways in which system professionals were perceived to create barriers to treatment entry included: unrealistic case plan and probation requirements; mandating treatment without providing a referral or resources; providing inaccurate or incomplete referral information; withholding referral documentation; and personal attacks motivated by racism, homophobia, and class bias. Another significant new finding was participants' reports that they successfully used drug court involvement as a means of holding system caseworkers accountable for providing treatment referral and support services as indicated in their case plans.

Monitoring and enforcement have been identified as important to treatment retention (Young, 2002). Participants reported that CPS and CJS follow-through on mandated treatment referrals was of critical importance to treatment entry. Mandating treatment without providing timely logistical support and compliance enforcement was

perceived as contributing to escalation of women's substance use and mental health symptoms, as well as increasing risks to the children who remained in their custody. Furthermore, several women who had already lost custody of children reported that lack of timely follow-through and enforcement directly contributed to suicidality and substance overdosing. The latter finding both confirms and expands on Roberts' (1999) finding that African American women reported substance use escalation as a primary means of coping with childhood and adult losses.

Participants' narratives both confirmed and added to existing literature on program-related barriers to treatment entry. The findings of this study confirmed literature indicating that African American women seeking treatment may be challenged by waiting lists (Allen, 1995; MacMaster, 2005) and housing instability (MacMaster). Previously identified barriers in transportation (MacMaster; Marsh et al., 2000; Rosen et al., 2004) and child care (Rosen et al.) were not reported as significant concerns for the women in this study. This may confirm Roberts and Nishimoto's (2006) findings that African American women rate intrapersonal factors as more salient than practical barriers to treatment. However, this difference also may be due to the fact that most participants were enrolled in residential programs that provided both transportation and childcare. A significant new finding emerged as a potential barrier for women referred to gender-specific programs. Several participants reported treatment avoidance because they were uncomfortable relating to other women, and specifically to other African American women.

As found in Roberts (1999), participants reported projecting negative experiences with system professionals onto treatment expectations and counselors. These projections only were apparent among participants without prior treatment experience, however all participants indicated heightened sensitivity to professional bias of any type and carefully assessed counselor attitudes during initial contact as found in Ward (2005). Literature on African American women and substance abuse treatment has indicated important counselor characteristics for improving treatment retention and outcomes. Several of these characteristics were described by participants as facilitating treatment entry namely providing encouragement and unconditional positive regard (Dakof et al., 2003; Ehrmin, 2001; Roberts), and instilling hope (Roberts & Nishimoto, 2006).

Participants consistently reported that an effective mandated treatment referral must consider their holistic life circumstances including individual motivation, losses, strengths, social support (especially family), logistical barriers, and resource needs. These findings further validated literature regarding multidimensional motivational factors in mandated treatment compliance (Marlowe et al., 2001) and specifically for African American women entering treatment (Dakof et al., 2003).

Participant narratives suggested that inviting African American women to express their perceptions, feelings, and experiences with mandated treatment could prove helpful in countering both low individual readiness and perceived discriminatory treatment in the mandated referral process. The majority of participants reported that they volunteered to be interviewed because they wanted their stories to be heard and expressed relief at feeling heard. They also indicated that it was important to be heard by someone who

cared, and for their stories to help others. These findings are consistent with the ideas of personal expressiveness, caring, and the wisdom of lived experience as expressed in Black feminist theory (Banks-Wallace 2000; Collins, 2001). Roberts et al. (2000) noted that identifying and sharing suppressed experience, as well as wisdom and strength, "can potentially be a critical protective factor in….self-image, self-esteem, and centeredness" (p. 905) for substance-abusing African American women who have internalized racism and social stigma.

Counseling Implications

The findings of this study suggested several steps counselors could take to reduce delays in treatment entry and improve enrollment rates. The majority of barriers women reported occurred within relationships and contexts before initial treatment contact. It is clear from these findings that if counselors and treatment programs wish to improve treatment entry rates among African American women with mandated referrals, they will need to expand their definition of treatment entry to include community outreach, interagency collaboration, and advocacy-oriented assessments. African American women's ability and willingness to comply with mandated treatment could be greatly improved by increased communication and collaboration between system professionals and treatment counselors (Azzi-Lessing & Olsen, 1996; McAlpine, Marshall, & Doran, 2001).

Counselors could support establishing or developing those relationships by providing accurate, up-to-date treatment resources to CPS and CJS referring professionals. These should include logistical information, an outline of integrated

services available through treatment, and potential benefits of treatment participation. Counselors also could make efforts to understand obstacles experienced by referring professionals, and should initiate or participate in cross-agency training. Important topics to consider include: CPS and CJS policies and procedures, assessing substance abuse severity, the importance of respectful interpersonal communication, and effective collaboration with families and intimate partners of substance-abusing African American women.

Caring relationship and feeling heard were significant themes in participants' narratives and should be considered in any interagency collaboration. Therefore every effort should be made to include African American women in the case planning and treatment referral process (SAMHSA, 2004). Referring professionals and treatment counselors also may want to consider connecting African American women with a peer mentor who is well-established in treatment and stable in her recovery, and who can 'be real' in addressing questions and concerns about treatment (Dakof et al., 2003).

Finally, results of this study suggested ways in which counselors could improve treatment entry at time of assessment for African American women with mandated referrals. Women have indicated a need to understand the boundaries between the referring agency (i.e. CPS or the CJS) and treatment. Carefully explaining confidentiality, privacy, privilege, and women's rights may contribute towards establishing trust (Burman, 2004). Counselors should not assume that African American women with mandated referrals have accurate expectations of treatment, and therefore should explore women's expectations and provide accurate information about the program, services and

potential benefits as necessary. They should also work with women to identify individual concerns and personal goals which may or may not parallel the objectives of the referring agency (Brown et al., 2000).

During assessment, counselors should thoroughly explore basic resource concerns such as food, housing, clothes, employment, and the needs of any dependent children. Any of these may be significant concerns for women entering both in- and out-patient treatment. Counselors also should thoroughly assess women's social support, and attempt to identify relationships that provide motivation or that serve as obstacles to treatment (Riehman et al., 2003). They should include time to assess the quality of women's interactions with system professionals and repercussions of the system intervention on individual and family stability. This information could prove valuable in identifying advocacy needs and in establishing working relationships with family, children, intimate partners, and referring professionals. Counselors should strive to instill hope, provide encouragement, and educate women about what it means to "succeed" in treatment (address fear of failure).

Limitations

The results from this study should be considered within the context of potential limitations. One potential limitation to the findings is the selection of long-term gender-specific treatment programs for data collection. The resulting sample population does not include the experiences of women who had not yet entered treatment, were referred to detox services, or who were referred to mixed-gender outpatient or partial hospitalization. Because two of the three sites were for women and children, only two women without

children were included in this sample. However, their stories suggested important differences in treatment entry issues. The inclusion of only one out-patient program is less of a concern as the majority of the participants had been in both types of treatment by the time of the interview.

It should be noted that this sample was comprised of economically marginalized women, and cannot be generalized to the perceptions and experiences of African American women from higher socioeconomic status. The location of this study in a major southeastern metropolitan area may impact the generalizability of findings to other regions and to non-urban populations. As regards race, it should be noted that the majority of participants would have interacted with African American female counselors and staff during treatment intake and assessment.

Another consideration is the use of convenience sampling. Because recruitment and interviewing were conducted on-site at treatment programs, participants may represent women who were more highly motivated to enter treatment, and thus more likely to be in attendance on the interview days. This would be especially true of the outpatient program. Given the nature of the study, it may be that women who volunteered were especially unhappy with the circumstances of their treatment mandate. This may have influenced findings concerning the role of the system and of child-custody, although it also would indicate a sub-group that is at particular risk for delays in treatment entry.

Finally, observer effects should be considered as a potential limitation. The PI was introduced to participants as a counselor and a graduate student who had experience working in the local community with women who were mandated to treatment. Steps

were taken to create a safe and comfortable interview environment, and to allow the participants to inform and educate the researcher. Nevertheless, a review of PI field notes and disclosure patterns in interviews indicate that participants may have been cautious in making certain disclosures to a White professional woman. One example is that women who expressed ambivalence about systemic racism when asked directly, were more likely to discuss the issue when asked about gender discrimination (i.e. differences in how Black and White women were treated). There were also instances where participants halted their narratives to search for a word that was more "professional," possibly indicating a desire to present themselves in a positive light.

On the other hand participants who reported having difficulty relating to "Black females" or who self-identified as professional and/or middle class appeared to be more at ease early in the interview. The majority of participants used circular disclosure, adding more depth and detail to their narrative as the interview progressed and they became more comfortable with the interviewer.

Future Research

The exploratory nature of this study uncovered several findings that merit further investigation. It would be helpful to replicate this study with larger samples of women who are and are not currently parenting, are referred through different sources, enter different types of treatment, and have different primary substances of abuse and severity of symptoms. It would also be valuable to interview or survey pairings of clients and referral professionals (i.e. caseworkers and probation officers).

Time and events between initial CPS or CJS intervention and treatment entry proved to be a significant factor in women's treatment entry. Tracking women between time of initial system intervention and treatment entry would further clarify individual, social, and systemic barriers to treatment entry. Evaluating assessment and referral procedures in both CPS and the CJS could identify training and resource needs, and areas for collaboration between referring system professionals and treatment intake counselors.

Information dissemination also was a critical factor as women indicated that having an accurate understanding of treatment services and benefits could increase their treatment motivation and facilitate their treatment entry. There is a strong need for advocacy research in this area which could include conducting community outreach education. One possibility would be developing and testing educational materials; these should be tested for efficacy at time of system intervention and also at time of treatment entry. It is recommended that any efforts in this area include representatives from the target population both in developing and implementing any intervention.

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APPENDIXES

APPENDIX A

INFORMED CONSENT

INFORMED CONSENT FOR INDIVIDUAL INTERVIEW PARTICIPATION

Thank you for coming today!

NOTE: After we discuss informed consent and any questions you have I will tape record your agreement to participate so that you do not have to sign any papers or reveal your identity. Is that okay? YES ____ NO ____

You have volunteered to be interviewed about your experience of being mandated to substance abuse treatment. The purpose of this study is to learn more about what it means to be told you have to go to treatment, how it affects you and your family, and what you expect from substance abuse treatment. The information that is collected from you and other women will be used to help referring agencies and treatment programs to improve services.

Before we start the interview, I will explain this consent form, answer any questions you have, and describe what is involved. If you change your mind about participating, you can leave at any time, and without any explanation. It is important that you are here today of your own free choice.

Here is a description of what to expect:

1. I will ask you for a made-up name. I will not ask you to give your real name. This is to protect your identity and privacy.
2. I will ask if you understand and agree to this consent form and to the interview. You do not have to sign any papers. Instead, I will audiotape your agreement.
3. I will write your made-up name on this form. You will get a copy to keep.
4. I will ask you to fill in a survey with basic information about yourself.
5. I will interview you about your experience. Anything you wish to share will be very helpful. You can refuse to answer anything you wish, with no explanation.
6. The interview will be audiotaped and I will also be writing notes so I can remember details. At any time you can ask for the tape to be turned off.

7. The interview will take anywhere from 45 minutes to two hours. The length is up to you. You can end the interview whenever you wish.
8. Upon completion of the interview (at time of your choosing) you will receive compensation for your time and participation (twenty dollars).

Participation risks:

There are no foreseeable risks for you greater than those encountered in daily life. Participation is voluntary. You do not have to be part of this research, you can change you mind and stop at any time. No one other than myself will know whether you participated or what you chose to share. Your real name will not be on any of the research information or results.

Participation benefits:

The benefit of this study is to better inform the treatment of other women like yourself who get mandated to substance abuse treatment. It is hoped that referring agencies and treatment program staff will use this information to improve their services. If you would like to receive a copy of the results of this study, please ask.

Privacy:

Because you are not providing your real name or signing any papers, there is no way of connecting your survey information or the interview tape with you as a person. If the results of this study are presented or published, any details that might reveal your identify will be changed. After this study is completed, the surveys and tapes will be destroyed.

One Exception:

There is one situation where your privacy is not protected. My profession requires that I do everything possible to protect the people I work with from harming themselves or others. I am legally obligated to act if I have reason to believe that you are in danger of harming yourself or someone else, especially if that other person is a child or an elder. The law requires that I report my concerns to the appropriate government agency.

If You Have Questions After the Interview:

If you would like to discuss the current study, please contact Kathy Newton at 404-377-0711.

If you have questions about your rights as a participant in this study, you may also contact the Institutional Review Board (IRB) at Georgia State University. The Review Board's job is to oversee the protection of research participants. The contact person is Susan Vogtner (Office of Research Integrity), her phone number is 404-463-0674.

A copy of this consent form will be provided for you to keep.

Do you have any questions at this time?

Are you willing to participate in this research? YES _____ NO _____

_____ ____ - ____ - ____ _____
Participant's made-up name Three number code Date

_____ _____
Student Investigator/Interviewer Date

Georgia State University
Department of Counseling and Psychological Services
Principle Investigator: Brian Dew
Student Investigator: Kathy Newton

APPENDIX B

DEMOGRAPHIC SURVEY

Participant pseudonym: _____

1. What is your age? _____

2. What is your race/ethnicity?:

____ Black/American
____ Black/African (country: _____)
____ Hispanic/Latino
____ Multiracial/multiethnic (including: _____)
____ Other: _____

3. When you were growing up, did you usually feel like your family had:

____ more than enough to live on; I always had what I needed
____ enough to live, but sometimes we struggled
____ not enough to live on; we were often struggling to make ends meet
____ we often didn't have enough food and/or a place to live

4. Now that you're an adult, do you usually feel like you have:

____ more than enough to live on; I always have what I / my children need
____ enough to live on, but sometimes it's a struggle
____ not enough to live on; I am often struggling to make ends meet
____ I often don't know where I'll get the money for food / utilities / rent payment

5. What are your primary sources of income (check all that apply):

____ part-time job (10-30 hrs/week)
____ full-time job (30-40 hrs/week)
____ odd jobs / cash jobs
____ childcare
____ family helps
____ child's father helps
____ church/community
____ Other: _____
____ disability / SSI
____ food stamps
____ TANF

6. What is your current housing situation:

____ private home (owned by myself)
____ private home (owned by family)
____ rented home
____ treatment housing
____ rental apartment
____ subsidized / public housing (section 8)
____ temporary shelter
____ temporarily homeless

7. Who do you currently live with (check all that apply):

____ I live alone
____ I live with my children
____ I live with my parent/s
____ I live with other family
____ I live with a significant other/intimate partner
____ I live with friends
____ I live with roommates
____ Other: _____

8. What level of education was completed by the people you think of as your mother and father?:

My mother completed:
____ some middle school
____ some high school
____ GED
____ high school diploma
____ some college/vocational
____ college degree

My father completed:
____ some middle school
____ some high school
____ GED
____ high school diploma
____ some college/vocational
____ college degree

9. What is the highest level of education you have completed?:
____ some middle school
____ some high school
____ GED
____ high school diploma
____ some college/vocational training
____ college degree

10. How many children do you have? _____

11. What are their ages? _____

12. If you have children, how many are currently living:
____ with you
____ with other family
____ with friends
____ in DFCS custody or foster care
____ adopted by other families

13. Are you currently facing any pressure from the Department of Family and Child Services (DFCS) (check all that apply)?

DFCS:
____ reported for child abuse/neglect
____ open child abuse/neglect case
____ children in foster care (temporary)
____ children in foster care (permanent)
____ temporary custody of children
____ mandatory urine screens
____ visitation rights
____ other: _____

TANF:
____ currently getting benefits/food stamps
____ benefits reduced due to alcohol/drug
____ benefits removed due to alcohol/drug
____ benefits will be reduced/removed if I fail to meet treatment requirements
____ mandatory urine screens
____ other: _____

14. Are you currently facing any legal pressures (check all that apply)?

____ waiting on a hearing date
____ waiting on sentencing
____ criminal charges
____ mandatory urine screens
____ drug court
____ probation
____ parole
____ other: _____

15. Who or what agency is requiring that you attend substance abuse treatment?
____ DFCS / CPS caseworker
____ TANF caseworker
____ Probation or parole officer
____ other: _____

16. Have you ever wanted to cut back or stop your drug or alcohol use? ___ Yes ___ No

17. Have you ever tried to cut back or stop your drug or alcohol use? ___ Yes ___ No

18. If you have wanted to or you have cut back or stopped, how did you do it? (check all that apply):

____ I just did it
____ Friends or family helped me
____ Prayer / faith
____ reading / self-help books
____ I went to support meetings (12-Step, etc)
____ I went to a substance abuse treatment program
____ other: _____

19. How long were you able to maintain that change?:

____ 1 week
____ 1-3 weeks
____ 1 month
____ 2-3 months
____ 4-6 months
____ 7-12 months
____ 1-2 years
____ other: _____

20. Do you feel like your drug or alcohol use has ever created problems for:

____ you
____ your education
____ your work
____ your friendships
____ your safety
____ your family (parents, siblings)
____ your children
____ your children's education
____ your children's health
____ your children's safety
____ your finances
____ your housing
____ physical health
____ mental health

____ other: _____
____ I have not experienced any problems

21. Please rank the three substances below that you have used the most / had the most problems with (1=primary, 2=secondary, 3=third):

____ marijuana
____ powder cocaine
____ crack
____ alcohol
____ PCP/angel dust
____ speed (meth, ice)
____ prescription drugs (type: _____)
____ club drugs (example: ecstasy, G, K)
____ heroin
____ other: _____

22. How many times before now have you been required to attend substance abuse treatment?
____ never
____ 1 time
____ 2-3 times
____ more than 3 times

23. How many times have you ever attended a substance abuse treatment program?
____ never
____ 1 time
____ 2-3 times
____ more than 3 times

24. Have you ever completed a substance abuse treatment?
____ never
____ 1 time
____ 2-3 times
____ more than 3 times

Thank you!

APPENDIX C

INTERVIEW QUESTIONS

1. Why did you choose to take part in this interview?

2. Why do you think (referral agency) told you to go to treatment?

3. Why did you decide to come to treatment?

4. How did you find and get into a treatment program?

5. How do you think your experience of being mandated would have been different if you were a man?

6. How do you think your experience of being mandated would have been different if you were a white (or Latina) female?

7. How does your experience of being mandated compare to that of other Black women?

8. How are women from different class levels treated the same or differently by the system? By treatment programs?

9. What is your opinion about women who ask for help with personal problems (including alcohol and drug use)?

10. What or who helped you get through the mandated referral experience and into treatment?

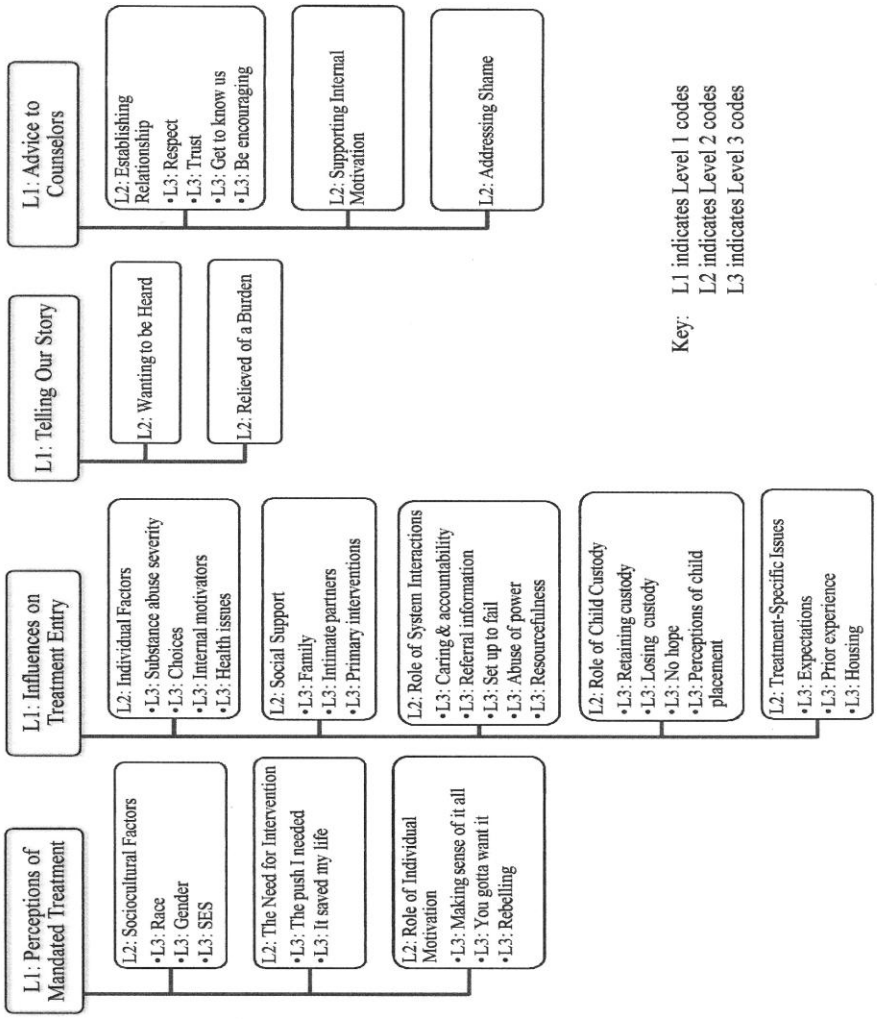
11. What would have been different if you had been offered treatment instead of being told you had to go?

12. What would you tell other women/other Black women about the mandate process?

13. Based on what you have experienced and learned from going through the mandate process, what would you like referring agencies and treatment staff to know?

14. What was it like for you to do this interview?

15. Is there anything else you would like to share?

APPENDIX D

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