Journal of Substance Abuse Treatment 130 (2021) 108474

Contents lists available at ScienceDirect

Journal of Substance Abuse Treatment

journal homepage: www.elsevier.com/locate/jsat

"A good mother": Impact of motherhood identity on women's substance use and engagement in treatment across the lifespan

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ARTICLE INFO

Keywords:
Motherhood
Substance use disorders
SUD
Treatment
Women
Child protective services
CPS

ABSTRACT

Background: Women are underrepresented in substance use disorder (SUD) treatment. Interpersonal and structural factors affect women's access to SUD treatment, but limited research evaluates how motherhood is a potential barrier and facilitator to engagement in SUD treatment. We focus on women from young to middle adulthood, and capture women's identities as mothers, caretakers, and grandmothers, outside of pregnancy and the postpartum period.

Methods: Study staff conducted twenty qualitative interviews with women in SUD treatment to assess experiences with SUD treatment, in which motherhood emerged as a key theme. Twelve women then participated in four focus groups centered on motherhood. The study audio-recorded and transcribed interviews, and two independent authors analyzed interviews, followed by group consensus.

Results: Most women identified their children and responsibilities as mothers and caretakers as important motivators to accessing SUD treatment. Motherhood was also a barrier to treatment, in that women feared losing child custody by disclosing substance use and few residential programs accommodate women with children. Multiple women expressed guilt about their substance use, sensing that it contributed to perceived abandonment or separation from their children. Reunification was important to SUD recovery.

Conclusion: Women with SUD who are mothers experience specific barriers to treatment engagement and recovery. Women need SUD treatment programs that address these interpersonal and structural factors across the lifespan.

1. Introduction

Globally, women are underrepresented in treatment for substance use disorders (SUD). Though women comprise one in three people with a SUD, only one in five women engage in various forms of SUD treatment that includes pharmacologic and behavioral therapies, particularly for opioid use disorder (OUD) ("United Nations Office on Drugs and Crime", 2015). Previous research on SUD treatment (including initial experimental studies using methadone) was mostly based on men, largely due to liability and heterogeneity concerns about engaging women of childbearing age in clinical research (Greenfield et al., 2007). Historically, women were excluded from outpatient addiction treatment because methadone and therapeutic community programs were often male-dominated, with female treatment retention rates declining since the 1970s (Sue, 2019). Addiction research has not fully explored gender-specific treatment and factors that contribute to gender-based disparities in treatment access.

Women with SUDs face unique social, structural, and interpersonal barriers that contribute to gender disparities in treatment (Greenfield et al., 2007). Women's substance use patterns are often relational with overlapping sexual and substance use partners and networks ("United Nations Office on Drugs and Crime", 2015; El-Bassel et al., 2012).

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https://doi.org/10.1016/j.jsat.2021.108474
Received 1 October 2020; Received in revised form 22 December 2020; Accepted 11 May 2021
Available online 14 May 2021
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Interpersonal factors that influence women's substance use and treatment outcomes across the lifespan are understudied yet are integral to understanding women's experiences with SUD (Meyer et al., 2019).

To date, minimal research has examined women's identities as mothers outside of pregnancy and how motherhood identity impacts access to drug treatment. Furthermore, public policies pertaining to substance use have also neglected to consider women's perspectives as mothers—not just pregnant mothers—who use drugs. Instead, work largely focuses on women's substance use and treatment during pregnancy or immediately postpartum (Falletta et al., 2018; Haller et al., 2003; Kuo et al., 2013; Preis et al., 2020; Sutter et al., 2017), along with fetal outcomes, including neonatal abstinence syndrome (NAS) from opioids (Klaman et al., 2017). The stigmatization of women with SUD is continually reinforced (Egan, 2018; Stone, 2015). Throughout the United States, multiple states pursue criminalization of women with SUD during pregnancy under child endangerment laws (Angelotta et al., 2016; Hayes et al., 2020; Miranda, Dixon, & Reyer, 2015). In 2014, Tennessee became the first state to enact legislation that defined opioid use during pregnancy as fetal assault; Oklahoma and North Carolina tried to pursue similar legislation (Burke, 2016). Twenty-three states allow civil prosecution of mothers who use drugs under child-welfare laws, and three states can commit pregnant women to SUD treatment without their consent (Miranda, Dixon, & Reyer, 2015).

During pregnancy and throughout the lifespan, mothers or caregivers who use drugs face possible criminal conviction, loss of child custody, and are subject to extensive surveillance throughout their pregnancies and while raising their children (Angelotta et al., 2016; Miranda, Dixon, & Reyer, 2015; Toscano, 2005; Wyatt et al., 2004). Black communities are disproportionately affected by criminalization approaches to SUD (Glaze & Kaeble, 2014), contributing to other health and social disparities, though the racial gap in incarceration for women has narrowed (Mauer, 2013). There is a dearth of research on how mothers navigate these obstacles and how structural inequalities influence women's engagement with SUD treatment. Few studies investigate the ways in which women's identities as mothers or caregivers—and by extension, society's perception of these identities that are often internalized—influence women's attitudes toward and access to SUD treatment.

In this study, we asked: how have women's identities as mothers facilitated or impeded their engagement in SUD treatment? We focused on themes of child separation, the involvement of child protective services, as well as structural and interpersonal factors that may have impacted mothers' decision-making regarding whether to access treatment. We defined motherhood broadly, encompassing women's identities as mothers, whether biological, adoptive, or as primary caretakers of children (i.e., grandparent). We aimed to gain a deeper understanding of how women's identities as mothers influence their engagement with SUD treatment to inform the development of gender-specific treatment strategies for care delivery.

2. Methods

2.1. Setting

The parent study, known as OPTIONS, was focused on HIV prevention in women in SUD treatment. The study recruited participants from the largest regional drug treatment provider, meaning they have the most people enrolled in treatment in New England. It includes outpatient substance use treatment (group programming, individual therapy, onsite psychiatric services), intensive outpatient treatment (IOP), an open-access model for initiation of medications for opioid use disorder (MOUD) (Madden et al., 2018), a 170-bed licensed residential services division, and a primary care center affiliated with an academic medical center that sees approximately 3800 patients per year. At least 300 individuals initiate treatment each month through the open-access model and most clients are on MOUD. In mid-2019, which is a generally representative time-point, of 5257 enrolled clients across all service divisions, 38% were women, approximately half were 35–54 years old, and 79% identified as Caucasian or non-Hispanic White.

2.2. Participant recruitment and enrollment for individual interviews

As previously described, we recruited participants for individual qualitative interviews for the formative phase of a parent study on perceptions of HIV risk (Fig. 1) (Qin et al., 2020). The study recruited participants through brochures and fliers placed throughout drug treatment facilities (Qin et al., 2020). Trained research assistants were onsite weekly at each of the treatment sites during the recruitment phase to inform potential participants about the project. Program staff could also refer potential participants via a dedicated phone line and a HIPAA-secured Qualtrics form. Research assistants screened all referred individuals for study eligibility. The inclusion criteria were: 1) identified as female (cis- or trans-woman); 2) age ≥18; 3) self-reported HIV-negative and not currently on PrEP; and 4) receiving treatment of any kind for any SUD at the partnering agency. The study staff excluded individuals if they were unable or unwilling to provide informed consent.

2.3. Participant recruitment and enrollment for focus groups

Research staff recruited focus group (FG) participants from the parent clinical trial, which took place in the same setting and applied the same inclusion criteria as the individual interviews. Individual interview and FG participants were mutually exclusive (Fig. 1). Additional inclusion criteria for the FGs were having at least one child regardless of the age of the child or legal custody status.

All participants in both individual interviews and FGs provided written and verbal informed consent. The Yale University Human Investigations Committee (IRB) and the drug treatment center's Board of Directors approved all procedures, and the research team registered the parent study on Clinicaltrials.gov (NCT03651453).

2.4. Individual interview procedures

We completed individual qualitative interviews with 20 women in private rooms at either the partnering drug treatment center or research study offices from December 2017 to February 2018. Two research assistants conducted the interviews, which lasted approximately 1 h. Semistructured interview guides gathered preliminary information on HIV prevention, focusing on substance use and SUD treatment. Although motherhood was not part of the original focus of these interviews,

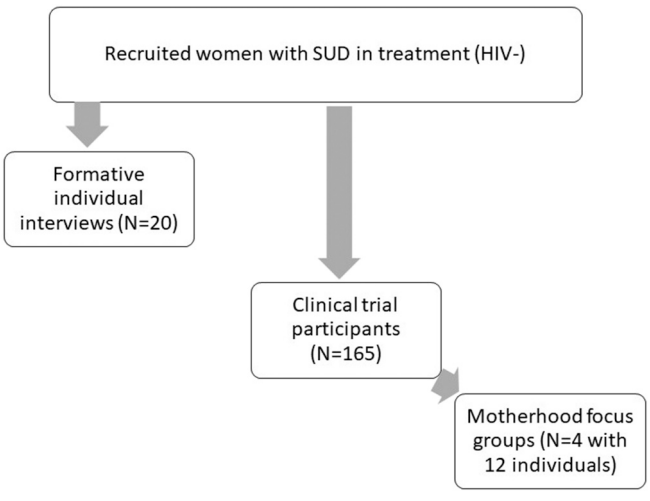

Fig. 1. Participant recruitment and enrollment.

motherhood emerged as a prominent theme in many interviews as we describe. The study compensated all participants for their time with a $20 gift card.

2.5. Focus group procedures

Four FGs were held at community locations chosen for their convenience and proximity to the partnering drug treatment center from October 2019 to November 2019. Before each FG, participants provided verbal consent, and completed a brief written anonymous survey that collected demographic information, including number and ages of children, how many children were currently in their care, duration of drug treatment enrollment, and type of SUD for which they sought treatment. FGs were facilitated by at least two members of the research team using a semistructured interview guide (Appendix A) that explored women's identities as mothers and motherhood as a potential barrier or facilitator to SUD treatment. We compensated participants with a $10 gift card for their time.

2.6. Data analysis

We audio-recorded individual interviews and transcribed them using a HIPAA-compliant transcription service and coded in Dedoose ("Dedoose Version 8.0.35 web application for managing, analyzing, and presenting qualitative and mixed method research data", 2018). Two authors (JM, YQ) independently coded the data using predetermined nodes as previously described (Qin et al., 2020). Research staff then imported excerpts from interviews containing the "motherhood" code into NVivo 12 (International, 2020) and merged with FG data for further analysis.

One member of the research team (CG) also audio-recorded and transcribed the FGs. Three researchers (ZA, CG, JM) read each transcript in full and generated a preliminary coding structure based on barriers and facilitators to SUD treatment in terms of individual, interpersonal, community, and structural levels, according to the Socioecological Model, as Fig. 2 shows (Bronfenbrenner, 1979). Two team members (ZA, CG) independently coded the transcripts in NVivo 12. The research team then added or consolidated additional codes as part of an iterative process resolved through group discussion. The team identified major themes using grounded theory, applying inductive reasoning (Strauss & Corbin, 1990), and the team extracted representative excerpts for each theme. The research team analyzed descriptively frequency of basic characteristics of participants from individual interviews ($n = 20$) and FG ($n = 12$).

3. Results

3.1. Participant characteristics

Among 20 interview participants, the mean age was 44 years (SD 10.1). Sixty-five percent of participants self-identified as non-Hispanic White ($n = 13$) and 20% of participants identified as non-Hispanic Black ($n = 4$), consistent with local and national data on women in SUD treatment (Substance Abuse and Mental Health Services Administration, 2019). Sixty percent of women reported a history of injection drug use ($n = 12$) and 85% reported a history of opioid use ($n = 17$). Seventy percent of women with SUD identified as mothers ($n = 14$) (Qin et al., 2020).

The mean age of FG participants was 42 years (SD 12) and mean time in treatment was four years. Half of FG participants identified as non-Hispanic White ($n = 6$) and 42% identified as non-Hispanic Black ($n = 5$). All participants identified as cis-gender women, and all had biological children (including live and deceased children). The mean number of biological children for each participant was 3 (SD = 1.4), with a mean age of 18 years (SD = 10.5). Forty-two percent of the women indicated that they had received no childcare support or assistance with parenting ($n = 5$), and only 17% of participants cited childcare support from a co-parent (e.g., spouse, partner, boyfriend/girlfriend; $n = 2$). All (100%) were receiving MOUD, and some (8%) were additionally receiving treatment for alcohol or cocaine use disorders.

3.2. Motherhood as facilitator to substance use treatment

3.2.1. Individual: Motivation

Caring for children was commonly seen as a motivator to access treatment that emerged as a key theme in three out of the four focus groups, and several interview participants cited it as the primary factor that facilitated access to treatment and prevented relapse.

> [My grandson] changed my life … Just doing homework with him, knowing I got to get him up the next day, gotta go to bed early…I thank God for him, I do. Because I don't know where I'd be, if I didn't have him living [with] me, I don't know if I'd have people over to the house getting high, I don't know where I'd be. If I would relapse you know.
>
> (FG 1 Participant)

If I had known that the [treatment center] was around when I was pregnant or even before I got pregnant, I feel like I would have went

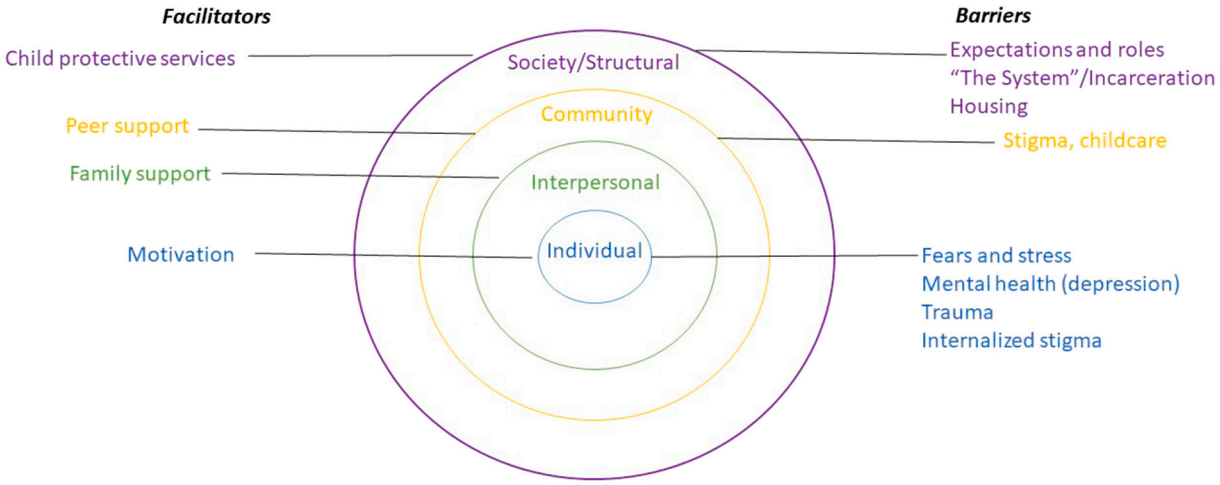

Fig. 2. Socioecological model of participant-identified barriers and facilitators to SUD treatment for mothers.

because I love my kids more than anything and I would do anything for them. Even with them not saying anything to me I'm a do it because that's what I'm supposed to do as a mother.

(FG 2 Participant)

Participants saw treatment as part of the duty of motherhood and an essential step in providing for their children. Referring to her children, another woman commented:

They're both the reason why you cry real hard and the reason why you're struggling. It makes me depressed I don't have my kids but at the same time they're the main reason I go seek treatment. Like I don't want to give up 'cause of them but at the same time I'm devastated that I don't have them.

(FG 2 Participant)

These participants found that being a mother can facilitate accessing SUD treatment by increasing motivation.

3.2.2. Interpersonal: Family support and grandparenting

Participants identified having family support with parenting as a facilitator to accessing treatment.

"I have family. They…could take care of the little ones you know…It was easy for me to get treatment with the children"

(FG 3 Participant)

Many of the women were the primary caregivers for their grandchildren, which they also saw as a strong motivator to seek treatment. One woman remarked:

All the motivation came from [my grandson] as far as we being in the shelter, getting clean, getting housing, all that is because of him. Because he would see me like "Grandma I want to come stay the night with you." I'm like grandma's getting it together, grandma's getting it together. So yeah he gave me a lot of motivation.

My kids though they seen me use drugs, they've seen me sick from dope, I mean, I don't want my grandchild to go through that. … I want him to know of drugs and know it's bad … Look where my kids end up. All three have been to jail from seeing it. They've been through too much with me being on drugs.

(FG 1 Participant)

Participants saw grandparenting as a second chance at parenting, an opportunity for women to give their grandchildren what they were unable to give to their own children because of their substance use. Thus, caring for grandchildren while in SUD treatment was a chance to break the intergenerational cycle of substance use.

3.2.3. Society/structural: State-sanctioned child protective services

For some women, involvement with and worry about child protective services (CPS) or the Department of Children and Families (DCF) led the women to access treatment because they were mandated to do so or because they felt worried about being mandated. "[I was] worried about [CPS] if I didn't get treatment" (FG1 Participant).

Importantly, treatment was not self-motivated but was mandated, leaving women little autonomy in the process: "Once you have the system in your life you have to get treatment ya know. You have no choice" (FG 2 Participant). CPS involvement—or the threat of CPS involvement—increased some women's access to treatment, but it is unclear if this led to long-term recovery as women were not independently and actively choosing to seek treatment for their SUD.

3.3. Motherhood as barrier to treatment

Several factors pertaining to motherhood negatively impacted women's ability and motivation to access SUD treatment programs. The most common themes that emerged from interviews and FGs included separation from children, structural factors (e.g., childcare, CPS involvement, housing, and incarceration), stigma and disclosure issues regarding substance use, and mental health.

3.3.1. Individual: Fears of child separation and stress of reunification

Many participants reported that physical separation from their children and/or loss of child custody was a driver of relapse and continued substance use:

I think what I'm struggling [with] now the most is that I worked hard for recovery and things didn't come back to me quick enough. Then I end up relapsing…and then starting the whole process. Like my kids are teenagers and they don't want anything to do with me now. Now they have the choice…And it sucks, it's like how long… I don't know. But as an addict I want him back now. It's just not happening the way I want it.

(FG 3 Participant)

After I lost my son, and after reality hit that the police weren't gonna give him back—I didn't even know where he was. Once I knew for a fact that I wasn't gonna just be able to pick him up and take him home, that's when I hit rock bottom and, yeah, went to the heroin.

(Interview participant)

I'm 39 years old and I'm just now getting into dope? But it's hard to cope with not having your kids. That's what led to some poor decision-making.

(FG 3 Participant)

These women who were separated from their children expressed a deep desire for reunification and often used substances to cope. One woman described how she started using opioids after losing custody of her children despite not having a prior history of opioid use.

The traumatic impact of separation from family persisted into adulthood and was seen as intergenerational. One participant reflected:

So they [my children] can come back to me 18–20 years later looking at me like why did you leave me, why did you give up on me, why didn't you fight for me? Because I have the same question for my mother. Why didn't you come back for me, you were supposed to come back for me after you got out of rehab. What happened? She never came back.

(FG 2 Participant)

This participant and others saw CPS involvement as a precipitating factor for substance use in response to separation from their children, potentially precipitating an intergenerational cycle.

3.3.2. Individual: Mental health (depression and trauma)

Several women reported struggling with mental health conditions. Untreated depression was a barrier to SUD treatment access. One participant commented:

When I'm depressed I don't want to see the sunlight…I don't wanna see nothing I don't wanna talk to nobody…It was like once my kids like really got taken…that put me into a whole big depression. Like after court I couldn't even go to the [drug treatment center]. I went, couldn't say I didn't go, but I was crying too much. I couldn't even open up my eyes.

(FG 2 Participant)

For this participant, separation from her children precipitated an episode of depression, inhibiting her motivation to engage meaningfully in treatment.

Trauma also interfered with women's perceived ability to both parent and addressed their addiction. One participant, speaking in the third person, commented on how many mothers who use drugs have unaddressed trauma, including "sexual trauma or…physical abuse trauma" that fuels continued substance use:

> When somebody becomes pregnant, they're not able to discontinue use, because they're still going through trauma, or…they do have their children, but then there's issues, because they don't know how to manage their addiction, as well as provide the care needed for their child…and now, they have to take care of another person, and now, they have to take care of themselves, and they were never able to work on that trauma they had.
>
> (Interview participant)

This quote suggests that mothers who have co-occurring SUD and psychiatric disorders are more likely to view motherhood as an additional stressor. Women with ongoing depression or trauma symptoms may need additional levels of support to care for themselves and their children, making access to both SUD and mental health treatment exceedingly difficult.

3.3.3. Community: Childcare and residential treatment options

The participant quoted next experienced housing insecurity, which was a barrier to accessing SUD treatment for mothers.

> There's only very few places that allow women [with] children. And it's such long wait lists…Talk about access? So, it's like none. So, when you want to get help where do you go?
>
> (FG 4 Participant)

Opportunities for temporary housing were rare for mothers with children, especially young children who needed on-site daycare. Recounting her experience living in a homeless shelter, a woman commented:

> I realized in that shelter…there was no type of programs in there where I can go to someone and say I'm looking for a job, or I got my kids with me I need daycare. …When you give shelter to a woman you should provide all those type of things.
>
> (FG 4 Participant)

This participant was one of the 42% of FG participants who lacked childcare. Seeking SUD treatment or employment may prove especially challenging for these women.

3.3.4. Society/structural: Expectations and roles of "a good mother"

Many participants held preconceived notions of how mothers should behave and parent their children, i.e., what they felt constituted "a good mother." Women reported a clear tension between society's expectations of mothers and their personal struggles with substance use. Most FG participants also expressed feelings of shame, regret, and guilt when they could not meet these socially constructed expectations of motherhood:

> I missed out on a lot and I have a lot of regrets you know…Because I wasn't a good mother I don't think. I mean, they ate, they were clothed, they had shelter, but still they didn't have time that I should've spent with them, they didn't have my time and they should've. They had seen me sick from the drugs you know. They shouldn't have had to go through that.
>
> (FG 1 Participant)

Another participant expressed that mothers who use drugs—compared to their male counterparts—are perceived as being unable to fulfill their respective archetypal role.

> I feel that there is sometimes a lot more shame and guilt around being a mom who's actively using than being a dad who's actively using.
>
> (Interview Participant)

The same participant also stated that men are more likely to be described as "functioning alcoholic[s] or functioning addict[s]" compared to women. Men are perceived as "functional" fathers during active substance use whereas women cannot be functioning addicts and therefore cannot be perceived as good mothers if they are using substances.

The expectation of being a mother became more nuanced when mothers lost custody of their children:

> [Once my] kid [went] out of state and [I] lost custody of my child…I wasn't a parent anymore…I'm not part of that decision making anymore. I lost that right when I lost custody.
>
> (FG 2 Participant)

In other words, to lose custody of one's child and to be physically separated from them results in no longer having the expectation, or even the identity, of being a mother.

3.3.5. Society/structural: "The system" and other structural barriers

Several participants referred to "the system" when describing the barriers that parents face when seeking substance use treatment: "So the system is terrible when it comes to helping parents, especially with parents with substance abuse. They don't feel we have a voice" (FG 4 Participant).

FG participants characterized the involvement of CPS as both a barrier to substance use treatment access and a reason for relapse: "I was more or less scared of going [to treatment] because I didn't want [CPS] to find out right then and there" (FG 2 Participant). Inherent in the process of seeking treatment is disclosing substance use, which many women interpreted as risky due to possible CPS involvement and loss of child custody. When asked about the ways in which being a mother might make it difficult to access treatment, another participant replied:

> When you're trying to hide your use from [CPS]…Like I didn't want anybody to know I relapsed this time, I probably would have gotten help ya know sooner.
>
> (FG 2 Participant)

This participant was interested in seeking treatment for her SUD after she had relapsed but did not due to fear of CPS involvement. Participants also avoided disclosure of substance use to CPS due to stigma: "There's still such stigma there really is…you're still judged" (FG 2 Participant).

Working with CPS to regain custody of children also proved to be stressful for some participants. The stress from CPS's added demands compounded the trauma from family separation:

> [Drugs] basically ruined my life…Because I don't have what I want the most…what I want the most is my kids but I can't get it, and it's like [CPS] is just dangling my kids in my face and [CPS] is like pushing me to relapse and I realize they're pushing me to do a lot of things but I can't do it.
>
> (FG 2 Participant)

Although the prospect of reunification with children was a motivator to seek treatment for this participant, the motivation was outweighed by the trauma of CPS involvement. This woman attributed her relapse to the harms that CPS caused in the process of attempting to regain custody of her children.

3.3.6. Society/structural: Impact of incarceration on motherhood

Several participants had histories of incarceration, and some women framed incarceration as a barrier to SUD treatment access postrelease. One participant recounted telling herself while incarcerated,

> Oh I'm gonna stay clean, I'll never go back, I'll never do this, I'll never do that. You say that when you're in jail but when you're home it's a different story. It's a totally different story.
>
> (FG 1 Participant)

Other participants described a cycle of moving among residential treatment facilities (often with their children), short-term detoxification programs, prisons, or jails and back to the community:

> Participant A: So they [women with children] give up and they start doing drugs again. Go home and they're back in the situation and [CPS] back taking their kids.
>
> Participant B: It's the whole cycle all over again…or prison, the whole cycle all over again (FG 4 Participants).

CPS involvement, and consequent loss of child custody, further led to substance use that increased the likelihood of incarceration, often related to violations of probation or parole.

3.4. Implications for substance use treatment programs

Many women were frustrated by a perceived lack of support from SUD treatment programs. In one FG, multiple women had specific recommendations for improving programs based on their experiences:

> Going through this whole process with my whole life I said when I get it together I want to start a group for women for, like a big brother big sister program. Someone to be at your side, go with you to places, help you filling papers, so when you stand up in front of the judge you can say my sponsor is here.
>
> (FG 4 Participant)

Participants said current programs were impersonal and understaffed. As stated, women felt they would benefit from a peer navigation system of advocates who have lived experience with addiction and the criminal justice system:

> It might be nice to get people who are really committed in their heart to the jobs that they go to for us to be able to have access. We need people to fight for us and not judge us. And advocate for us. 'Cause they give you specific steps in courts and it says you have to be in the community, or get some kind of community help, or have some kind of church home or something like that. But you don't have people that want to do those type of things with you.
>
> (FG 4 Participant)

This participant emphasized peer-support and community-level engagement as key factors that would bolster SUD treatment programs and improve women's adherence to treatment. In stating the need for increased advocacy, this participant urges SUD treatment programs to provide tangible community support such as a peer-navigation system for the women they treat.

4. Discussion

In this qualitative study, we explored how motherhood identity, which was previously shown to influence women's substance use patterns (Meyer et al., 2019), also influenced women's engagement with SUD treatment. The focus on motherhood was driven by themes that emerged de novo from formative interviews with women enrolled in SUD treatment within a larger study of HIV prevention in women. This dedicated substudy allowed us to further explore specific facets of motherhood that functioned as facilitators or barriers to treatment engagement. Furthermore, our study makes an important contribution to the literature in that it explores the impact of women's motherhood identity on SUD treatment access across young to middle adulthood *outside* of pregnancy and the immediate postpartum period.

Participants identified key facilitators and barriers to SUD treatment for mothers who use drugs (Fig. 2). Motherhood motivated women to access SUD treatment, consistent with previous qualitative research with men and women with histories of injection drug use who identified becoming a parent as a major factor in seeking addiction treatment (Neale et al., 2007). Missing from this prior study was a gender-specific approach, which we fill here. Our findings are also consistent with a similar study from Canada (Elms et al., 2018), in which participants identified fear of losing custody of children and lack of childcare as the two major barriers to engaging in drug treatment and motivation from being a mother as a facilitator to treatment. Participants' characteristics differed considerably from our study with all participants identifying as White, only 60% of participants having engaged in drug treatment, and most women having methamphetamine use disorder. The remarkable similarities in findings despite differences in study populations suggest that findings may be reflective of the experiences of mothers who use drugs from a variety of backgrounds.

Using data from the 2010–2014 National Survey on Drug Use and Health (NSDUH), one study revealed that adults with OUD living with a child (who were more often women) were less likely than adults with OUD not living with a child to be enrolled in treatment, citing financial issues, access, and stigma as key barriers to treatment enrollment (Feder et al., 2018). Similarly, in our interviews and FGs, participants identified stigma, fear of CPS involvement, and structural and community barriers as key factors influencing women's willingness to seek treatment, consistent with previous qualitative and quantitative research (Cockroft et al., 2019; Davis & Yonkers, 2012; Gueta, 2017; Liebschutz et al., 2000; ME, 1982; Stringer & Baker, 2018). Another study that used 2003–2010 NSDUH data to explore gender-based stigma in addiction treatment, specifically related to women's identities as mothers and/or wives, reported that women were significantly more likely to report perceived stigma as a reason for not seeking SUD treatment compared to their male counterparts (Stringer & Baker, 2018). To advocate for improved access to treatment for women with SUD, societal stigma surrounding women's expectations as mothers must be challenged and questioned.

Participants often referred to "the system" when describing barriers to care. Here, participants interpreted "the system" as different manifestations of structural violence that they faced (Davis & Yonkers, 2012; Farmer et al., 2006; Metzl & Hansen, 2014)—such as the involvement of CPS, housing insecurity, incarceration—and how these structures influenced their access to care as mothers with histories of substance use.

Most participants mentioned CPS as a structural barrier to SUD treatment access, largely due to fear of child separation; this finding is consistent with previous research conducted on obstacles to care for mothers with SUD (Falletta et al., 2018; Gueta, 2017; Kenny et al., 2015; Liebschutz et al., 2000; Rockhill et al., 2008; Schmidt et al., 2019; Stone, 2015). Up to 80% of open CPS cases involve substance use, thus warranting an interrogation of how CPS influences access to SUD treatment for mothers and other women (Nishimoto & Roberts, 2001). CPS disproportionately involves mothers with fewer interpersonal resources and those of lower socioeconomic status (Lussier et al., 2010). In recent reports from Canada, child custody loss was significantly associated with increased overdose rates among women, with Indigenous women experiencing twice the odds of unintentional overdose compared to non-Indigenous women who had not experienced child custody loss (Thumath et al., 2020). Legal scholar Dorothy Roberts, who has termed CPS a "family regulation system," stated that CPS "affirmatively harms children and their families while failing to address the structural causes for

their hardships," particularly for Black women and their families, a group that is underrepresented in our study and in SUD treatment programs nationwide (Roberts, 2020).

By threatening women with loss of child custody, CPS effectively discourages women from disclosing substance use and seeking treatment, further compounding the stigma that mothers who use drugs feel. Research has explored efforts to further combine CPS programs and substance use treatment programs, as they have "similar values" (Drabble, 2007) but contribute to the continued criminalization of parents who use substances. Alternatives to parent-child separation and child welfare services must be more extensively researched and prioritized (Wyatt et al., 2004). These alternatives could include supported SUD treatment, mental health resources, childcare, and financial resources provided to caregivers of children. An investment in building healthy and stable families could be mirrored by a divestment in CPS as it currently exists.

Interestingly, some women in our study stated that CPS involvement facilitated SUD treatment access, though coercively. Although research has shown legally mandated treatment to increase access to care and promote treatment retention among pregnant and postpartum women (Nishimoto & Roberts, 2001), motivation significantly mediated the association between voluntary involvement and treatment retention (Hampton et al., 2011). People who are pressured into SUD treatment have reported decreased motivation to change (Cahill et al., 2003). The effect of legal coercion on SUD treatment outcomes have inconsistent results and are rarely gender-specific (Klag et al., 2005). Women with SUD are already subject to increased state surveillance, criminalization, and trauma. Thus, legal coercion should no longer be framed as a mechanism to increase women's access to SUD treatment.

There is little extant research on other aspects of how the so-called system broadly impacts SUD treatment access for mothers outside of pregnancy. Women with SUD often must navigate siloed and fragmented systems of care and support—integrated and coordinated approaches are needed. Pregnant and parenting women with SUD who had access to programs that coordinated childcare, prenatal care, psychoeducational workshops, and mental health treatment experienced improved treatment outcomes (Ashley et al., 2003).

Women with SUD in our study consistently stated that motherhood motivated them to access SUD treatment. If motherhood facilitates women's willingness to not only access but to remain in addiction treatment, programming is needed that is specific to women's identities as mothers. Currently, few SUD treatment programs provide on-site childcare or offer community-level interventions and/or peer-based support (Elms et al., 2018; Neger & Prinz, 2015). Participants in our study cited peer-navigation networks and peer advocacy as important aspects of SUD treatment program reform. Women critiqued vague notions of "community support," which were often alluded to by court systems and SUD treatment programs but were not realistic options for women in some communities because of the stigma of being a mother with SUD. Efforts to reform SUD treatment programs should employ a community-based participatory research (CBPR) approach, which would involve mothers with SUD, administrators, and providers at SUD treatment programs, and community-based organizations, to ensure that interventions are informed by the lived experiences of mothers with SUD (Israel, Schulz, Parker, Becker, & Community-Campus Partnerships for, 2001).

4.1. Limitations

While reflective of participants' experiences, this study is not without limitations. We explored the viewpoints of women with SUD already enrolled in SUD treatment programs in Connecticut, representative of women who were able to overcome the many barriers to SUD treatment access. Thousands of women with SUD in the United States are unable to overcome the significant structural barriers to addiction treatment. Future community-based research should be more inclusive of perspectives of women with SUD not yet enrolled in treatment. All women in our study were HIV-, which may have impacted their motivations to engage in SUD treatment. Generalizability may also be limited because the majority of our participants self-identified as non-Hispanic White women, though this is illustrative of the national demographic profile of women who are diagnosed with SUD and engaged in treatment (Substance Abuse and Mental Health Services Administration, 2019). It was also the intent of this qualitative sub-study to prioritize the depth of these women's experiences over breadth that would reflect all women's experiences.

4.2. Future directions

Research has observed significant racial disparities in SUD treatment access and completion, with Black and Latinx patients being less likely to enter addiction treatment programs (Saloner & Le Cook, 2013) and more likely to die from opioid overdose (James & Jordan, 2018; Lippold et al., 2019). Black patients' experiences with implicit bias also impacts access to SUD treatment, as they are less likely to have their pain recognized and treated, including with opioids (Hoffman et al., 2016). These racial disparities highlight the need for SUD treatment reform, requiring increased partnership with Black and Latinx communities in the development of policies and structures that support access to treatment (James & Jordan, 2018). A need continues for gender-disaggregated data that acknowledge issues of intersectional stigma, with a specific focus on barriers to SUD treatment that affect mothers of color.

According to the most recent SAMHSA report (SAMHSA, 2020), 49% of U.S. drug treatment facilities offer programs specifically tailored to adult women and 24% to pregnant or postpartum women, but these are not necessarily geared to address the unique needs of mothers. Women report increased satisfaction and feeling more supported in their recovery when enrolled in a single-gender drug treatment program as opposed to mixed gender (Greenfield et al., 2013), which may indicate treatment tailored specifically to mothers, as opposed to parents more generally, may have better success. To effectively engage women in SUD treatment, treatment programs must incorporate the perspectives of mothers with SUD and be attuned to the barriers that this patient population faces. Many FG participants had internalized societal expectations of being "a good mother," but these societal standards warrant further interrogation: what does it mean for a mother with active substance use to be a "good mother"? Whose definition of "good" is applied? What expectations are realistic given minimal social and structural supports accessible to mothers who use drugs?

There are scant but important examples in the literature of treatment programs responsive to the needs of mothers with SUD. The Breaking the Cycle program for mothers who use substances found that a relational approach to treatment that focuses on the relationships between mother and child, mother and service provider, and service provider and community partners resulted in longer time in treatment (Andrews et al., 2018; Racine et al., 2009). This effect was strongest when mothers enrolled in the prenatal period or immediately postpartum. Multiservice or integrated treatment programs for pregnant and parenting women with SUD are community-based and women-centered, designed to be one-stop shops "that address women's physical, mental, and social-economic well-being" (Rutman et al., 2020). These programs provide integrated wraparound services that help women to address the needs described by the participants of this study, including basic subsistence, childcare, and mental health services in addition to evidence-based practices for SUD treatment. In doing so, they effectively deliver care while addressing the social and structural barriers to care that many women experience.

5. Conclusion

Women with SUD who are mothers experience specific interpersonal and structural barriers to treatment engagement and recovery including

CPS involvement, incarceration, mental health needs, and lack of childcare. Facilitators to SUD treatment access for mothers included the motivation associated with caring for children, family support networks, as well as certain facets of CPS involvement. Women need SUD treatment programs that effectively address these factors across the lifespan to engage in meaningful treatment.

Author disclosure statement

Research and career development support provided by the Doris Duke Foundation (CSDA 2017080 to JPM). Funding sources played no role in data collection, analysis, drafting of the manuscript, or decision to submit the manuscript for publication. Dr. Meyer reports receiving research support from and serving on a scientific advisory board for Gilead Sciences. Dr. Yonkers reports receipt of consulting fees from Athenen. No conflicts of interest to declare.

Author statement

Meyer obtained funding for the parent study. Adams, Ginapp, Qin, Price, and Meyer helped design the study and participated in data collection and analysis. Adams and Ginapp wrote the paper. Price, Qin, Madden, Yonkers and Meyer participated in interpretation of the data and critically revised the paper.

Declaration of competing interest

The authors have no conflicts of interest to disclose.

Acknowledgement

We wish to express gratitude to DeShana Tracey for diligently executing data collection and to all of our study participants for sharing their perspectives.

Appendix A. Supplementary data

Supplementary data to this article can be found online at https://doi.org/10.1016/j.jsat.2021.108474.

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