

A Qualitative Study of Exodus Graduates: Family-Focused Residential Substance Abuse Treatment as an Option for Mothers to Retain or Regain Custody and Sobriety in Los Angeles, California

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In this article, 21 long-term, poly-substance abusing mothers describe how they successfully completed an 18-month family-focused residential substance abuse treatment program in southern California that helped them retain or regain custody of their children. Their stories and experiences with specific program characteristics and approaches of this rare treatment option are described, in their own voices. Policy implications for child welfare and parental substance abuse treatment are examined in light of these success stories.

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Many parents seeking intensive substance abuse treatment face a Faustian choice: surrender custody of their children to the authorities to enter a comprehensive, long-term residential treatment program and likely lose parental rights; or figure out how to kick the habit while raising their children, paying the rent, holding down a job, and socializing with family and friends in an environment rife with temptations to use. Although child welfare and substance abuse professionals have long discussed jointly addressing this issue (Christian, 2004; Drabble, 2007; Maluccio & Ainsworth, 2003; Osterling & Austin, 2008; Pajulo, Suchman, Kalland, & Mayes, 2006; Rockhill, Green, & Furrer, 2007), few such programs exist. This gap, as well as empirical research about this approach's efficacy, leaves the current and future well-being of the children of many chronically addicted parents in jeopardy.

An estimated 9% of American children reside with a substance-abusing parent (Child Welfare Information Gateway [CWIG], 2003). These children are at risk for a range of developmental, social, and psychological delays, including child maltreatment (Carlson, 2006; Connors, Grant, Crone, & Whiteside-Mansell, 2006; Hogan, Myers, & Elswick, 2006). An estimated one-third to two-thirds of child maltreatment cases include parental substance abuse (CWIG, 2003; Young, Boles, & Otero, 2007).

Programs that include specialized attention to treatment needs of women rarely accommodate their children. Although the precise number of beds available is not known, in 2005, only 8% of California's treatment facilities provide beds for children (Substance Abuse and Mental Health Administration [SAMSHA], 2006b). As context, 3% of treatment programs that responded to a nonrepresentative national survey—a total of 347 sites in the United States—enroll pregnant or postpartum mothers (SAMHSA, 2006a). In California, 4.5% of admissions to substance abuse programs in 2004 were pregnant women while an estimated 59% were parents of minor children (Boles, Werner, Young, Gardner, Chang, Dennis, & Otero, 2006).

Developmental improvements were noted among children living with their mothers in residential substance abuse treatment (Connors,



Bradley, Whiteside-Mansell, & Crone, 2001); mothers reported improved parenting skills (Hiersteiner, 2004). While more knowledge is needed about how this treatment affects children (Connors et al., 2006), a preponderance of research illustrates that allowing mothers to retain custody helps them complete treatment and maintain sobriety and abstinence afterward (Carlson, 2006; Center for Substance Abuse Treatment, 2001; Connors et al., 2006; D'Arlach, Olson, Jason, & Ferrari, 2006; Greenfield, Brooks, Gordon, Green, Kropp, McHugh, Lincoln, Hien, & Miele, 2007; Greenfield, Burgdorf, Chen, Porowski, Roberts, & Herrell, 2004; Grella, Joshi, & Hser, 2000; Hiersteiner, 2004). Mothers mandated into residential treatment who retained custody of their children stayed in treatment longer and were more likely to complete the program than mothers in intensive day treatment (Nishimoto & Roberts, 2001). Mothers in family-friendly substance abuse treatment were more likely to remain drug free compared to those who lost or voluntarily relinquished custody of their children (Daley, Argeriou, McCarty, Callahan, Shepard, & Williams, 2000).

Family-friendly substance abuse treatment integrating parenting concerns and allowing children to remain with their parents would greatly reduce foster care utilization. After paying for program costs, a 12-month residential treatment program for pregnant mothers was estimated to save \$3,072 to \$32,722 per mother, including savings from criminal justice and foster care (Daley et al., 2000).

A few published pieces recount experiences of parents who completed substance abuse treatment (D'Arlach et al., 2006; Hiersteiner, 2004; Milligan, Wingrove, Richards, Rodan, Monroe-Lord, Jackson, Hatcher, Harris, Henderson, & Johnson, 2002; Sword, Niccols, & Fan, 2004). This study presents the experiences of 21 mothers who successfully completed the Exodus program, a family-friendly substance abuse treatment program at Shields for Families. Shields implemented Exodus in 1994 in Housing and Urban Development-funded transitional housing (Keith Village) in central Los Angeles. Exodus provides comprehensive residential substance abuse treatment, incorporating and addressing the multiple, overlapping identities and responsibilities of each person seeking help (McComish,

Greenberg, Ager, Messenmacher, Orgain, & Bacik, 2003). Each family receives individualized, comprehensive case management services throughout and beyond the 18-month program: This includes individual intensive substance abuse treatment for the parent(s) as well as an array of programs and services addressing parenting, health, mental health, education, employment, financial management, legal assistance, children's socialization experiences, and so on. From 1994 through 2001, approximately 80% of parents who began Exodus successfully completed the program (Taylor & Miller, 2000); many of these parents retained or regained custody of their children. Financial considerations aside, the importance of keeping children—safely—with their parents cannot be ignored.

Of the 21 parents in this study, 16 entered Exodus due to substantiated child maltreatment reports; all of them successfully reunited with their children during program participation. These women's voices are rarely heard. Their stories demonstrate how Exodus enabled them to solve their Faustian choice of seeking substance abuse treatment and remaining parents. While their experiences may not be generalizable, they represent the best outcome of this treatment modality and provide insight into how substance abuse treatment and child welfare practices can jointly support and help children and parents, rather than forcing parents to choose between helping themselves and helping their children.

Method

Sample

A purposive, deviant, nonrandom sample of 21 parents who had graduated from the 18-month Exodus program were recruited and interviewed between October 2007 and May 2008. Participants agreed, in writing, to allow access to their files, take part in a one-on-one interview and complete three standardized surveys (not reported here). Those who did received a \$20 stipend.

Finding potential participants who had moved off-site proved mostly unsuccessful. Los Angeles's dearth of affordable rental housing (Taves, 2009) and longstanding moratorium on Section 8 vouchers

meant that graduates who moved often relocated far away, and other graduates remained residents at Keith Village. Most participants had graduated within two years; the rest graduated two to five years earlier. Demographic characteristics of recent and older graduates did not differ significantly.

Procedure

After approval from Shields' and the University's Institutional Review Boards, the principal investigator attended a weekly alum meeting at Keith Village to describe the study and solicit participants. Subsequent meetings were attended by a master's of social work (MSW) student irregularly until interviews were completed.

Prospective participants were asked to sign a release form permitting case file review to determine suitability for the study (i.e., child welfare involvement and successful completion of the program, which included completion of GED/high school graduation). The approved study design assumed that agency case files were retained for eight years and easily accessible from storage. Instead, files were retained for less time and storage was so random and haphazard that many files could not be located for prospective participants, an unanticipated consequence of agency-based research.

Those whose files were located and met study criteria were contacted by one of five female second-year MSW students who scheduled an evening or weekend interview at Keith Village. Two bilingual students were fluent in Spanish. Two were African American, and one was Asian. To the degree possible, the race/ethnicity of the participant was matched with the interviewer's to increase the participant's comfort and reduce bias (O'Brien & Bates, 2003). An agency employee served as witness for the informed consent procedure (providing child care, if necessary). Interviews took 45 minutes to 2.5 hours to complete: each audiotaping was transcribed to a password-protected file and destroyed after its final use.

A semistructured protocol containing 17 open-ended questions covering three areas of interest guided each interview. The first section solicited initial motivations to enter the program, whether and how motivations changed while in treatment, program experiences,



and benefits. The next section gathered more details about program participation, asking what worked best and why, what was most difficult and why, how participants would rate the program and why, how they viewed the staff, and whether and how participating in the program changed parenting. Demographic and socioeconomic data were also collected.

Data Analysis

Relevant socioeconomic and family characteristics were gathered from case files and interview responses. The author retyped each individual transcript and then regrouped responses so each of the 14 open-ended questions had all of the 21 responses contained together. These versions were read numerous times to identify themes and patterns of responses about motivations to enter the program, experiences in the program (which a focus on parenting), and life after graduating.

Findings

Socioeconomic and Family Characteristics

Of participants, 86% were African American; the rest were Latina or white. These women ranged from 26 to 48 years of age, averaging 39. Contrary to stereotype, 62% of these mothers have or had a long-term relationship with the father of one or more of their children. Four were married, three were divorced, one was widowed, and one was engaged. Most of these men were high school graduates or completed some college; many worked and all were actively involved in family life. Among unmarried participants, four maintained longstanding relationships with the fathers of one or more of their children.

While all of the participants parented full time, four worked full time, and three worked part time. Seven attended college, and nine were actively seeking employment.

Average monthly income (from all sources) was \$1,324. One participant's income came solely from employment. Others relied on a combination of 2 to 9 cash and fungible benefits, averaging 4.6 per participant. Temporary Assistance for Needy Families; food stamps; school meals; Medicaid; and Women, Infants, and Children were the



most common, followed by unemployment insurance; housing assistance (Section 8 voucher); reduced heating/electricity costs; reduced telephone services; Supplemental Security Income; Old Age, Survivors, Disability, and Health Insurance; General Relief; Veteran's benefits; or employment-related benefits.

Monthly rents for Keith Village residents ranged from \$140 to \$439. Average rent for the four with housing subsidies was \$245; for the rest, it was \$280. Off-site participants paid monthly rents from \$98 to \$1,800 and \$835 average. None received housing subsidies.

Substance Abuse Histories

Participants recounted chronic poly-substance abuse of 2 to 28 years in duration, averaging 18 years. Each reported long-term, daily use of two or three substances—most commonly alcohol, crack cocaine, marijuana, and crystal methamphetamine. Nine participants completed or dropped out of outpatient or short-term residential treatment programs previously, including two Exodus graduates who relapsed after the death of a child and a partner, respectively. A number of participants experienced long periods of homelessness; many participated in illicit activities to feed their habits and their children during this time.

Seven participants were in therapy and took medication to treat diagnosed mental illness; 10 managed chronic health problems including asthma, diabetes, emphysema, or high blood pressure. Eight participants reported experiencing domestic violence. Two were the perpetrators rather than the victims, an unexpected finding. Another six participants were victims of sexual abuse as children. Of the 10 participants, 6 with criminal justice histories had been incarcerated for one month to four years for possessing illegal substances, shoplifting/vandalism, prostitution, and/or assault.

Children, DCFS, and Child Custody

Participants had birthed from one to seven children (average = 3.7); collectively, they had 78 children. Of these children, 48 lived with their mothers, and 6 resided with family members. Additional offspring lived independently as adults, and at least two were deceased.



A substantiated DCFS investigation was the initial motivation for 14 participants to enter Exodus. Four retained custody (nine children in total), although two sent a child to live with a relative.

Of participants, 12 lost custody of their children prior to entering Exodus. However, each of these 12 participants regained custody over nearly all of the 39 detained children whose ties to their mothers would likely have been severed within 12 months of placement, per federal law. Two participants reported that one of their children was in the physical custody of a close relative, and another was working with DCFS to reunify with some of her children residing with their father. Only one participant, with one of her children in her custody, had had her parental rights terminated for older children who were adopted years earlier.

Motivations for Substance Abuse Treatment

Parenting was the prime motivating factor for participants to enter Exodus, as this comment reflects: “We tried a few times prior to that happening, but we could not bring our children with us and I did not want to be separated from them, so we didn’t think about entering the program” (01, p. 1)¹.

One participant initially entered to get housing: “When I got here, I just fell in love with the lifestyle of recovery, and I also got my kids back” (12, p. 3).

Participants were painfully aware of how their substance abuse impaired their parenting, as one noted: “Parenting on drugs . . . was, like, you let them do the craziest things just so they would not interfere with you” (05, p. 4). Another comment embellishes:

I knew I would end up knocking them up, so I would scare them enough to where they would either pee in their pants or go crawling into bed and under the covers shaking. And I don’t ever want to cause that to them again, do that damage. I have learned to apologize. (08, p. 14)

1 Each direct quote is referenced by participant’s assigned number and the page of the transcript where it was found.





What Was Difficult

Although they learned to appreciate it, eight mothers felt that sharing their personal lives and feelings with others in group settings was the most difficult part of their program participation. Three said that the rigidity of the first month in treatment, living with roommates, was the hardest; two others who expressed pride in earning their GEDs said that they hated going to school.

Four participants who entered without their children said that the unrelenting, desperate pain they felt missing their children was the most difficult part of the program. Conversely, another four participants were stunned, horrified, and overwhelmed at how badly their children behaved. One mother commented:

When I came here . . . they made my pay attention to what was going on with my son because . . . it's not all about me. It's about me dealing with my kids and my behaviors as well. And that is just how it works here, so I had to get him into therapy, I had to have him analyzed and put on medication for his behavior . . . there was a lot going on with him, every day, something new. (07, p. 3)

One additional participant said that fighting to get her children back from out-of-home care was the most difficult because, "They were up for adoption because I had messed up for so long" (12, p. 4). Shields staff's excellent relationship with DCFS facilitated this mother's ability to convince the judge to extend time limits and eventually regained custody of her children.

Most Would Not Change Anything

Of the participants, 12 said that they would not change anything at Exodus; another said that it should be replicated widely. Another four mothers complained that some mothers were difficult or should not have been admitted. Two participants reluctantly complained about a specific staff member who, they believed, was disrespectful. One participant recommended adding exercise programs, bemoaning the fact that everyone at Exodus gained weight because food tasted so good and they no longer used drugs to cut their appetites. This participant's comment summarizes, "They have child development for children, they





have mental health services, they have different programs for women who have children, small children and big children . . . they have outside classes you can take. They have so many things to offer" (06, p. 2).

What Worked and Why

These mothers gave Exodus an average ranking of 9.3 on a scale ranging from 1 to 10 where 10 was the best. One noted "It's . . . not just the treatment. It's a lifelong process, a lifelong commitment to recover" (08, p. 12). Another mother, homeless and living on the streets for 17 years, said that the program gave her back her life. The program's staff and philosophy also warranted comments:

They counselors are wonderful. They really take the time to deal with your issues and try to help you whatever your needs are, whether it's food, clothes, legal matters, mental issues, whatever. That's a plus for me. They are not just trying to work with the drug program. They get all of the areas. 'Cause you know, as addicts, we tend to get in trouble every now and then, and, you know, we have warrants out and they help us clear that up, and they have went [sic] to the extent of going out of state for some people to clear their warrants. So that's a beautiful thing. (10, p. 7)

I got new friends. They taught me to open up, to take suggestions and look at myself if I needed anything for me, for my daughter. Financial aid, they helped you, they helped you . . . I didn't have no income for a while. They didn't kick me out. They didn't kick me out! . . . They never said, OK, well, the money to us is more important. Never. If I needed money because I didn't have no food stamps or something, they would give me food vouchers to go buy groceries, whatever, whatever, whatever we needed. Whatever we needed here, we were able to get as far as necessities. We don't ever have to go without. Ever. Ever. (15, p. 7)

Parenting classes, individual therapy, and informal guidance from peers and staff about parenting were particularly helpful:

I know I wasn't always a great mom, and I didn't really know





a lot of things about being a mother because I was never mothered myself. (13, p. 6)

I didn't really have any parenting skills . . . so coming here with the help of parenting classes and everything showed me things I was doing wrong and which I kind of knew I was doing wrong, but it showed me how to do things in a different way. You know? Like, you could still be strict or discipline without hitting or cursing or being verbally abusive. (14, p. 3)

When I was growing up, my people believed in whipping, and that is how I started raising my kids, with whippings. I learned that there is [sic] other ways to parent, you know, and I don't have to hit my kids all the time for them to listen to me or whatever. And I don't have to yell and curse at them all the time. So it really has changed my parenting skills. (19, p. 5)

After six children being taken away from me at birth, I was willing to do something different. I was raised in a foster home, you know, since the age of two . . . I went through problems there, and it seems like . . . every step of my life has been . . . downhill as a child, all the way up to like two years ago. And I looked back on my life and I seen [sic] everything that I've gone through and then, I mean, I just got tired, I just thought, you know, it was time for me to win, it was time for me to have things, it was time for me to responsible, and that motivated me to do it—just waking up another day. (13, pp. 2–3)

I'm not smoking crack today. I'm not using, and [I] learned to be a parent, learned to communicate with the kids, instead of yelling and hollering at them all the time. (09, p. 1)

Some mothers emphasized their newfound ability to see and understand both how their substance abuse had impaired their parenting, and their treatment was improving it:

I know . . . if I wouldn't have an addiction, I probably would have been a better parent. As long as I'm sober, they look up



to me highly, but as soon as I'm messing with the drugs, it's all disrespecting. I love how, right now, our relationship is . . . well, we tell each other we love each other. . . . A lot of stuff here can help you in whatever kind of problems you're having as far as being a good parent. (04, p. 6)

Before, it was just, basically, "Hey, go into your room so we can get on the couch and get high." That is no life for the kids. But here, we go out, do stuff. [Exodus] taught me to be proactive because I am not using drugs anymore, which is a good thing. I can talk to my kids now. (11, p. 5)

Participants appreciated that they were encouraged to determine their own lives in a program that embedded treatment into every service and program offered:

This program is not a "program" where they take your food stamps and your EBT card. You actually had all that in your hands, you pay rent, you pay the light bill, you pay your gas, you buy your own food. (12, p. 3)

They didn't make me feel less of a person for my addiction. They instead wanted to nourish me and make sure I get this—that way, I can live. (12, p. 4)

They don't really push you to do nothing: they give you suggestions. And if you are serious about it, you are going to follow them. And if you are not, you are going back and getting high again. (19, p. 3)

This is a very good program, very structured, very good. It's caring, it's nurturing, helping. If you utilize this program to the fullest you will succeed. When you have friends and you know your peers and even job opportunities, just all kinds of benefits you would get from here. You get a lot from this program. I'm a part of Shields for the rest of my life. This is going to be something that is part of my life forever. (15, p. 6)

Discussion and Conclusions

The 21 mothers in this study unanimously credit the Exodus program for their success overcoming chronic poly-substance abuse while also retaining or regaining custody and improved parenting of their children. Although some complaints were rendered, these mothers repeatedly emphasized and expressed appreciation for the manner in which each of them was encouraged to choose and assemble different services and parts of Exodus so that it worked for her. Critical of other substance abuse treatment options, they embraced Exodus' comprehensive, family friend approach, identifying it as key to their ability to take responsibility for and address three interrelated aspects of their 18-month treatment, as individuals, parents, and family members. Even among those who encountered difficulties during participation, these mothers fervently believe that Exodus was the only place that provided the help they needed, in a way that was respectful as well as efficacious, for them, their children, and their families.

In this regard, Exodus functioned as a "community of caring," offering these mothers interrelated, focused programs and services that structured opportunities for them to fundamentally rebuild their lives. The mothers in this study developed strong relationships with other mothers in the program, forging protections against temptations to revert to old patterns. Their children befriended each other as well. Although not explicitly stated by any participant, these mothers seemed aware that they had recreated themselves and forged a new community for their family, and some seemed in awe of this accomplishment. Perhaps that is why so many participants referred to Exodus as "a safe haven."

One participant's comment is particularly apt here:

All they want, you know, is love. That's all they really want: love. Of course we have to take care of them and feed them and stuff like that, but most of the time, all a child really wants is love, to know that their parent loves them, and that's what they teach us. How to love and care for our children and not mistreat them. (10, p. 8)

These mothers perceived their experiences in Exodus as love as well: tough love, certainly, but unconditional support for what they knew would be the most enormous challenge of their lives.

Study Limitations and Recommendations for Future Research

These findings cannot be generalized due to the sample's heterogeneity and small size. Social desirability bias may have led some respondents to censor negative experiences and embellish positive ones; the modest \$20 incentive might have exacerbated this trend.

Larger and more diverse samples and follow-up studies of long-term graduates as well as program dropouts would enhance understanding of the effectiveness and impact of Exodus and suggest which subpopulations of mothers would best benefit from this treatment option. Baseline and longitudinal measures of children's well-being, perhaps compared to children in similar situations who were placed in out-of-home care, would shed light on whether and how this treatment option affects children, and reveal areas where child welfare practitioners can improve on child-specific components. Cost-effective and cost-benefit analyses comparing program costs to costs of child welfare, criminal justice, and other system costs would also be informative.

Despite its limitations, this study adds to existing knowledge supporting family friendly residential substance abuse treatment and offers additional support and justification for jointly addressing substance abuse treatment and child welfare practices for parents. It does so by showcasing the voices of extremely poor, relatively uneducated, highly marginalized, chronic substance abusing mothers who succeeded with substance abuse treatment while retaining and building on their identities as individuals as well as mothers, preventing or reunifying with their children in out-of-home care. The growing numbers of now faceless and nameless mothers struggling with their addictions and parenting responsibilities are likely eager to have this opportunity to change their lives, as well as the lives of their children, in the many positive ways that have transpired among and between this study's mothers.



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Einbinder

Child Welfare

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