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'Don't Leave Me Hanging': Homeless Mothers' Perceptions of Service Providers

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Abstract

Few interventions have been developed for substance-abusing homeless mothers. Among those interventions, high dropout rates (up to 85%) are consistently reported. Understanding homeless mothers' experiences with service providers may be an important first step to understanding ways to increase treatment engagement. Therefore, the current study used qualitative methods to gain a better understanding of homeless mothers' perceptions of service providers. A total of 28 mothers who were currently residing at a homeless shelter in a Midwestern city participated in three focus groups. Overall, mothers held negative perceptions of service providers related to understanding, support, and fear. Based upon this study's findings, recommendations are offered to improve service delivery and guide future research.

Keywords

Homeless mothers; substance abuse; treatment engagement; service providers

In recent years, the number of homeless families has increased in the United States with an estimated 535,447 individuals identified as a member of a homeless family (U.S. Department of Housing and Urban Development, 2010). Previous literature has examined risk factors for becoming homeless, as well as the challenges associated with homelessness. One challenge experienced by a high percentage (38% to 56%) of homeless mothers is substance use (Center for Substance Abuse Treatment [CSAT], 2009). Unfortunately, attempts at developing interventions for homeless mothers with substance use disorders have limited success, and programs report high treatment dropout rates (Sacks et al., 2004; Smith, North, & Fox, 1995). To engage and maintain homeless mothers in treatment, exploring those factors that impact their decisions to seek out and remain in treatment may be important. Experiences with service providers likely impact treatment engagement and retention; therefore, this study uses qualitative methods to better understand those experiences.

Homeless mothers face several challenges, including unmet medical needs (Lewis, Andersen, & Gelberg, 2003) and high rates of sexual and physical abuse (Bassuk et al., 1996; Styron, Janoff-Bulman, & Davidson, 2000). Bassuk and colleagues (1996) found lifetime prevalence rates of physical or sexual abuse as high as 92%. Mental health problems and substance use disorders are also more prevalent among homeless mothers than the

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general population (Bassuk, Buckner, Perloff, & Bassuk, 1998; Zlotnick, Tam, & Bradley, 2007). Due to these risks, an understanding of their experiences with service providers may provide invaluable information to guide future research and intervention efforts.

Although substance-abusing homeless mothers are one of the most vulnerable segments of the homeless population (Kim & Crutchfield, 2004), previous literature has noted few attempts at developing interventions for this population. Emergency and transitional shelters are the primary intervention for homeless families (Culhane & Metraux, 2008; Weinreb & Rossi, 1995). Studies examining homeless mothers' perceptions of shelters indicate that mothers often report shelter use as a last resort and that shelter rules are too restrictive (Lindsey, 1998a; Meadow-Oliver, 2002). Among the few studies examining interventions for substance-abusing homeless mothers, Sacks et al. (2004) found that women assigned to a specialized therapeutic community, which included homelessness prevention interventions focused on parenting, employment, housing, and social support, showed more positive outcomes than those assigned to a standard therapeutic community. An earlier study (Smith et al., 1995) compared two treatment interventions (residential and nonresidential). Women assigned to the nonresidential group were more likely to drop out of treatment or not begin treatment (Smith et al., 1995). The overall dropout rate for both conditions was very high—85%. Additionally, 15% of the mothers originally enrolled in the project never began treatment. The high dropout rates in the Smith et al. study (1995) are not unique; in fact, treatment dropout rates are high among homeless individuals regardless of intervention type (Orwin, Garrison-Mogren, Jacob, & Sonnefeld, 1999; Stahler et al., 1993; Zerger, 2002). Although these interventions showed evidence that homeless mothers can benefit from treatment (e.g., reduced substance use), engaging and maintaining homeless mothers in treatment remains a challenge (Sacks et al., 2004; Smith et al., 1995).

Several factors may prevent substance-abusing homeless mothers from engaging in treatment. Previous literature shows that women in general face several individual, relational, structural, and systemic barriers to treatment (CSAT, 2009). Some examples include cost (Grant, 1997; Green, 2006; Substance Abuse and Mental Health Services Administration, 2009), individual's denial of problems (Grant, 1997; Tucker, Vuchinich, & Rippens, 2004), concern for what others may think (Saunders, Zygowic, & D'Angelo, 2006), and child care (Brady & Ashley, 2005; Taylor, 2010). Additional barriers include distrust of authority figures and service providers. Some researchers suggest that distrust may be a persistent barrier among homeless women because of their histories of victimization (Zeger, 2002). Given that the relationship between mothers and service providers may be crucial to engagement and maintenance in intervention efforts, this study provides the first in-depth exploration of those experiences.

Although no study has examined substance-abusing homeless mothers' perceptions of service providers, several qualitative studies have examined homeless youths' perceptions of service providers. These studies show that positive relationships with service providers are important to homeless youth (Thompson, McManus, Lantry, Windsor, & Flynn, 2006). For example, Nebitt, House, Thompson, and Pollio (2007) reported positive relationships between youth and shelter staff as a key component of successful outcomes among youth. Youth responded well when service providers were trustworthy, empathetic, and understanding (Darbyshire, Muir-Cochrane, Fereday, Jureidini, & Drummond, 2006; French, Reardon, & Smith, 2003; Thompson et al., 2006) but responded poorly when service providers were disrespectful and overly rigid (Thompson et al., 2006). While differences in the needs of substance-abusing homeless mothers and homeless youth clearly exist, these studies highlight the important role service providers can play in the lives of those experiencing homelessness.

Homeless mothers with substance use disorders are likely to be in contact with several different service providers including those employed at shelters, the child welfare system, and other social services agencies. The current study used information collected from focus groups of women residing in an emergency homeless family shelter to assess how they perceive their interactions with service providers across various systems. Cosgrove and Flynn (2005) stated that for research to be maximally useful to homeless mothers, the mothers need to be included in the research process; therefore, a phenomenological research design was employed. Phenomenological research is defined as the study of human experiences through the individuals' descriptions of their experience (Creswell, 1994). Creswell (2007) suggests using a phenomenological design when there is a need for a deeper understanding among individuals who have experienced a common phenomenon. The focus of phenomenological studies is not to solve problems but rather to gain an understanding of how people experience the problem (Willig, 2008). In summary, the phenomenological research design was chosen for this study to provide homeless mothers a voice regarding their experiences with service providers. This approach can provide deep insight and understanding of their experiences that may be integral to improving service delivery, which in turn may increase treatment engagement. Therefore, the current study focused on two overarching research questions: 1) How do homeless substance-abusing mothers describe their past experiences and interactions with service providers?; and 2) how do homeless substance-abusing mothers hope to be treated by service providers?

METHODS

Participants

A total of 28 women were recruited from a homeless family shelter in a large Midwestern city. Eligibility criteria were that women: 1) had physical custody of a biological child between the ages of 2 and 6 years, 2) met *Diagnostic and Statistical Manual of Mental Disorders*, fourth edition, text revision (DSM-IV-TR) criteria for a substance use or alcohol use disorder, and 3) were currently residing in a local family emergency shelter and met the federal definition of homelessness. The majority of the mothers were African American (60.8%), 32.1% were White, and 7.1% reported Mixed ethnicity. Their ages ranged from 18 to 40 years old, with an average age of 29.2 years old (*SD* = 6.4). The mothers had an average of 3.1 children (*SD* = 1.68), whose ages ranged from newborn to 18 years old; additionally, 3 mothers were currently pregnant. Eight (28.6%) of the mothers reported having children removed from their custody; 4 of these mothers still did not have custody of all of their children. Sixteen (57.2%) of the mothers were single/never married, 7 (25%) were divorced, 3 (10.7%) were separated but still married, and 2 (16%) were legally married. In the prior 90 days, mothers reported using alcohol or drugs 51.7% (*SD* = 38.6) of the days. Five (17.9%) mothers reported receiving inpatient treatment and 5 (17.9%) mothers reported receiving outpatient treatment for a substance use disorder. Eight (28.6%) mothers reported receiving inpatient services and 9 (36%) mothers reported receiving outpatient services for treatment of an emotional problem. The mean age that the mothers first experienced homelessness was 26.4 years (*SD* = 7.7); 2 mothers were younger than 18 years old when they first reported being homeless. In the past year, the average number of days mothers reported living in their own place was 205 days; otherwise, they lived with a family member (*M* = 113 days), with a friend (*M* = 21 days), in a shelter or mission (*M* = 23 days), or in another indoor place (*M* = 1.6 days). (Days spent at other locations were less than 1 day.)

Measures

The assessment battery was administered by a research assistant within a private office at the shelter. A range of assessment interviews and self-reports were included. In particular, a

demographic questionnaire was administered to assess sociodemographic characteristics of the mothers and their children. The variables included age, self-identified ethnicity, current marital status, income resources, homeless experiences, treatment experiences, and mental health history of mothers, as well as age, gender, and ethnicity of their children. The Computerized Diagnostic Interview Schedule (CDIS; Robins et al., 2000) was administered as a screening tool to determine formal eligibility of the mothers. CDIS is a structured comprehensive psychiatric interview containing 263 items based upon DSM-IV criteria and is administered to women by a computer. Modules to diagnose substance abuse and dependence were administered. The Form-90 (Miller, 1996) was also used in this study to measure quantity and frequency of alcohol and other drug use in the prior 90 days. The instrument is semistructured and provides a recent history of substance use using the calendar method. The Form-90 also provides information regarding physical and mental health service utilization, employment, and housing. It has shown excellent test–retest reliability for indices of drug and alcohol use in major categories (Tonigan, Miller, & Brown, 1997), with Kappa's for different drug classes ranging from 0.74 to 1.0.

Focus Groups

Focus groups are an effective method of assessing clients' perceptions and attitudes and allow professionals to understand reality from the clients' point of view (Kruegger, 2000); therefore, focus groups were the preferred method of interviewing for the current study. A total of three focus groups were held from July to August 2009 at the family shelter. The focus groups used for this study were designed as part of a larger, ongoing study seeking to develop an effective intervention for homeless mothers with substance use disorders. The overall aim of conducting the focus groups was to gain information from the mothers about their needs and desires from treatment to aid in the development of an intervention, which is the objective of the ongoing study.

The focus groups were semistructured and explored four general topics, which included mothers' current basic needs, their prior experiences with the systems of care, the type of assistance they would like to receive, and interpersonal issues and treatment needs (see Table 1 for the list of questions relevant to the current study). While the interviewers did follow the general question guide, the semistructured format and conversational nature of focus groups made it possible for mothers to underscore what they believed to be important in their lives. Consequently, many mothers discussed their experiences with service providers, and it became apparent that developing a meaningful understanding of those data could provide important guidance for intervention efforts.

Procedure

The Ohio State University's Institutional Review Board approved all research procedures prior to beginning the study. Women were recruited to participate in the focus groups through a local homeless family shelter. After ensuring eligibility criteria and obtaining informed consent, women completed a 3-hour assessment battery with a research assistant. Mothers were compensated with a $40 gift card. This study reports data about demographics, substance use, homelessness experiences, and mental health service utilization to characterize the sample.

After completing the assessment interviews, mothers participated in the focus group interview, which lasted between 1.5 to 2 hours. Two female moderators facilitated each group. The moderators attempted to provide a safe and nonjudgmental environment and assured mothers that they were not affiliated with the shelter. Consistent with phenomenological research, the researchers asked open-ended questions and used prompts

and probes when more detail or clarification was needed. Each group was audio-recorded with the use of two digital voice recorders.

Data Analysis

Two undergraduate research assistants transcribed the focus group interviews in full detail. Following Corbin and Strauss's (2008) suggestions for coding, the first author then read the transcripts from each interview in their entirety. Next, sections of the transcripts where the women discussed service providers were identified and coded. Open coding was used to identify common concepts, and then axial coding was used to compare and combine concepts to create overarching themes. Quotes were then selected from the transcripts to illustrate themes. The number of statements relevant to each theme and category was then counted. Given the conversational nature of focus groups, it was decided that both original statements made by mothers and agreement statements made by other mothers would be included in the frequency counts to provide a full representation of the data.

RESULTS

During the focus groups, the mothers discussed their previous experience with service providers from a variety of settings, as well as how they wanted to be treated by service providers. Therefore, the findings were organized into two categories: a) past experiences, and b) how mothers hope to be treated. In total, there were 275 relevant statements identified; 173 statements were coded as past experiences with service providers, and 102 statements were coded as how mothers hoped to be treated by service providers. Table 2 provides specific details about the frequency of statements relevant to each theme. Themes from both categories are identified and discussed in more detail below.

Past Experiences

Mothers' descriptions of their past experiences with service providers from various settings revealed that overall, women held negative perceptions of service providers. These perceptions were categorized into three themes, which included: 1) the perception that service providers did not understand them, 2) the perception that service providers were not supportive of them, and 3) fear of service providers.

Perception That Service Providers Do Not Understand—"You Don't Know What This Person Has Been Through Before They Got Here, Them and Their Kids, It's a Lot"—Mothers' perception that service providers did not understand them was influenced by their reports of feeling disrespected and judged by service providers. Many mothers described service providers with "nasty attitudes," with one mother saying, "Have you guys ever been to the welfare office and you feel like they're using the paper out of their purse to help you?" Several mothers reported that rude behaviors and disrespect discourage them from wanting to work with service providers. Feeling judged also added to mothers' perception of lack of understanding by service providers. Many mothers reported that service providers, including medical professionals, "looked down" on them. Women described experiences of being looked at like "we are nothing." Several women also noted that they felt some service providers judged them because of their drug use.

Several mothers reported feeling judged for their past mistakes, which also appeared to be related to increased feelings of being misunderstood. Prior eviction, poor credit history, and criminal records were described as significant barriers to housing for many mothers. For example, several mothers reported that prior evictions prevented them from qualifying for public housing vouchers. Many women reported that they wanted service providers to attempt to understand their unique situations. One mother explained this by saying, "I have

one eviction. Figure out why I got this eviction. Ask me what happened … give me a chance to talk. Don't judge me by my cover." They also noted that when efforts are directed toward turning their lives around, service providers do not appreciate or understand their efforts, as one mother explained:

> Yeah, everybody makes mistakes, but at the same time, people should see that we [need] a second chance to prove to them, OK, that we're out here doing what we need to do. But at the same time, you are making it seem like we're not out here doing this, that, and the third.

Perception of Service Providers as Unsupportive—"They Got You Doing All This Stuff and They're Still Not Helping You"—Most mothers reported that service providers were not providing sufficient assistance. Many mothers noted that they felt they are given long lists of things to do but are not provided with enough guidance to complete the tasks. Some women reported that service providers intentionally did not provide them with enough assistance. For example, one mother said, "There's other ways [to] help us and they just don't want to." Many mothers felt that there were resources and programs that could help them, but it was difficult to find them because service providers would not always assist in finding them. Some women reported understanding that they needed to take personal responsibility but also reported that when they reached out for assistance, they were disappointed with the amount that they received.

Several women also stated that service providers were a significant source of discouragement. One mother reported feeling upset because a service provider told her she would not be able to acquire decent employment because of her criminal record. Women stated that many times, service providers would "downgrade them." Numerous mothers said that service providers did not acknowledge the positive steps they were taking and focused only on the negatives. For example, one mother said, "Yeah, just recognition, that's all I ask for, just recognition. You so busy telling me what I ain't doing, you missing everything that I am doing." And some mothers reported feeling like service providers had given up on them and did not care about them. A few mothers described the way service providers treated them as being "heartless." One mother said, "They don't tell you nothing, [they say] 'I'm going to get my paycheck and that's it, I don't care about these people.'"

Fear of Service Providers—"I Have a Fear, Will They Say This Stuff to Children Services? Will This Be Turned in? You Know What I Mean? That's a Constant Fear I Have"—Many mothers reported some feelings of fear in regards to service providers, but the particular fear differed among mothers. One mother reported having an overall fear of those in authority, while other mothers reported fear of certain agencies or particular service providers. The fear of losing their children was common, and many mothers said their children were all that they had. In particular, several mothers reported fear of the state's children's services department.

Women's fears appeared to be a barrier to communication with service providers. For example, many mothers withheld information about their substance use, because they feared that: a) substance use information would be reported to government agencies, b) they would lose their public assistance, or c) their children would be taken away. While many of the mothers experienced generalized fear and distrust in regards to sharing information with service providers, in some instances, specific experiences with service providers caused fear and distrust. One mother said that in the past, a case manager told her that if she had one more baby, the case manager would transfer her case. Because of this, the mother did not tell the case manager that she was pregnant until late in her pregnancy. The case manager

transferred her case, and consequently, the process of adding the baby to the health insurance card was delayed.

How Mothers Hope to Be Treated

Mothers' descriptions of how they hope to be treated by service providers were generally the opposite of how they reported being treated and were categorized into three themes: 1) desire to be understood, 2) desire for positive support, and 3) need to trust service providers.

Desire to Be Understood—"I Feel if I Would Get an Advocate That Actually Paid Attention to Me and Really Realize What I Do Think, I Would Feel Three Times Much Better and I Would Be Able to Let That Wall Just Break Loose"— When discussing desirable qualities among service providers, many mothers expressed a strong desire to be understood. Mothers noted that they wanted someone who would listen to them. One mother described her ideal service provider by saying, "I would want somebody to actually sit down and listen to me and basically let them know my side of the story instead of them jumping down my throat talking about 'you need to do this, that, and the third.'" The mothers said they felt like they had gone through so much in life that it would be helpful to have someone understand their unique situation. Some mothers expressed gratitude and relief because they were able to discuss their problems during the assessment interviews and focus groups.

Mothers wanted to work with service providers who could relate to their experiences so that they would be more understanding. Some mothers said they thought it was difficult to relate to college-educated service providers because they did not have a lot of education themselves. Past experiences with service providers who were not empathetic led some mothers to believe it was impossible for anyone to understand them unless the service provider had been in their situation. Therefore, some mothers wanted service providers who had previously been homeless. One mother stated:

> We need somebody on our level, and I'm pretty sure we ain't had 20 years of college in our pocket, but it should be somebody who could relate to us, who you know, would not make us feel so bad for being in this situation or make us feel so ugly about ourselves.

Desire for Support—"I Need Somebody There Because You Need the Guidance, You Need the Extra Push, You Need That Pat on the Back"—Many of the mothers spoke of how difficult it was to be a single mother and to not have anyone to help or talk with; therefore, many mothers reported a strong desire for extra support. Women reported wanting service providers to acknowledge the positive steps they are taking and to have a positive attitude. They wanted service providers to provide them with more guidance and assistance. Many mothers said it is important that when service providers set goals with them, they also need to help them meet their goals; as one mother said, "Don't just leave me hanging." Many of the mothers explained how important it was for service providers to care about their job and "put their heart into helping." If a service provider seemed to care about them and wanted to help, women noted that they would continue to work with that service provider. In fact, one mother was able to identify a past case manager who she wanted to work with again because she felt that this case manager cared about her.

Trust—"I've Gone Through So Much and I'm So Young, You Know What I Mean? I Can't … I Don't Trust Nobody, I Don't Trust People"—The mothers stressed it was very important that they be able to trust their service provider and that they be assured that everything they discuss would be confidential. Mothers said they would only be able to talk with their service provider about personal problems if they were able to trust

the provider. Mothers said they wanted to be able to build a trusting relationship with service providers, but they also acknowledged that it takes time. One mother noted that she had previously been able to build a trusting relationship with her substance abuse counselor with whom she had worked for 8 years. Some women noted that they do not trust anyone, and others noted that no matter how much they trust someone, there were still things, such as their childhood, that they would not feel comfortable discussing.

DISCUSSION

The current study adds to the limited number of studies on substance-abusing homeless mothers by providing insight into mothers' perceptions of service providers, as well as what women desire from service providers. In general, descriptions of how women report being treated by service providers did not match how they reported wanting to be treated. Mothers in this study reported dissatisfaction with service providers, which is consistent with the findings of previous studies of homeless single adults (Hoffman & Coffey, 2008) and homeless youth (Thompson et al., 2006). Similar to those studies, lack of support (Thompson et al., 2006) and disrespect (Hoffman & Coffey, 2008; Thompson et al., 2006) were identified as major grievances. Therefore, the negative perceptions of service providers found in the current study do not appear to be completely unique to this sample.

Substance-abusing homeless mothers, however, likely differ from other homeless populations because the women are responsible for their children, which appears to be associated with unique concerns. Fear of service providers was a significant concern among mothers in the current study, and this fear is not commonly mentioned in research with single-adult homeless individuals and homeless youth. Fear may be a more central concern of substance-abusing homeless mothers because of the potential consequences if their substance use is reported. Mothers in this study reported that their children prevented them from seeking substance abuse treatment, because they feared that their children would be taken away. This finding is consistent with previous literature indicating that children are barriers to treatment for women with substance use disorders (Brady & Ashley, 2005; Finkelstein, 1994; Taylor, 2010). Mothers also feared having their substance use reported because of concerns that their public assistance would be revoked. These findings indicate that the criminalization and the potential punitive consequences of substance use create fear among homeless mothers and is a barrier to treatment engagement.

Previous research has shown that homeless mothers (Cosgrove & Flynn, 2005; Meadows-Oliver, 2002) and mothers with substance use disorders (Brady & Ashley, 2005; Finkelstein, 1994) face stigma and negative judgment by society. Service providers have the potential to positively impact these mothers by providing them support and understanding. Unfortunately, many of the mothers in the current study indicated that their experiences with service providers contributed to their feelings of being judged and misunderstood. Additionally, some mothers reported the belief that it was necessary for service providers to have experienced homelessness to be able to understand and relate to them. Given that stigma may act as a barrier to treatment among women (Brady & Ashley, 2005; Finkelstein, 1994), it is important that service providers work to decrease substance-abusing homeless mothers' feelings of stigma and ensure that they are not contributing to those experiences.

The mothers wanted service providers to provide more assistance than was provided. Mothers tended to interpret the perceived lack of guidance and support as an indication of service providers' lack of care and desire to assist them. While service providers' perceptions cannot be assessed from this study's data, a previous study by Lindsey (1998b) examined service providers' perception of factors that help and hinder homeless mothers. Lindsey (1998b) found that service providers ranked perceived attitude and motivation of

the homeless mothers as the most important factors related to successful restabilization. Lindsey's findings (1998b) indicate that service providers may view the mothers as being personally responsible for their current experience of homelessness. That is, service providers perceived individual factors as more important than structural factors (housing, employment, etc.) in the resolution of homelessness.

As suggested by Lindsey (1998b), possibly, service providers withhold assistance if they do not identify mothers as sufficiently motivated to help themselves. However, this approach may not ultimately best serve homeless mothers because lack of motivation might be associated with learned helplessness, or the perceived absence of control over their situation (Abramson, Seligman, & Teasdale, 1978; Burns, 1992; Kartalova-O'Doherty & Doherty, 2010). Furthermore, given individual differences among mothers, some mothers might simply require more assistance toward achieving goals than other mothers. So although the service providers likely do not have negative intentions, and in fact, may be seeking to encourage independence among the women, it appears that in general, the mothers interpret providers' encouragement toward independence negatively. In particular, women described feelings of not being understood or cared about by service providers, given the perceived inadequate level of assistance. It may be beneficial for service providers to talk openly with homeless mothers about how much help is needed by each mother and then flexibly and collaboratively agree upon those activities for which the mother and service provider will be responsible.

Limitations and Strengths

One limitation of the current study was that the sample of homeless mothers was currently residing at a homeless shelter for families. During the focus groups, many of the mothers may have focused on their recent experiences while residing at the shelter, and therefore, the results may not be as applicable to understanding how mothers perceive service providers across different service systems. Additionally, all women were currently utilizing the service system and may have different perceptions of service providers than homeless mothers who do not to utilize services. Furthermore, all mothers admitted to substance use to be included in the current study. As highlighted earlier, fear associated with admitting to substance use may have prevented some mothers from participating in the focus groups. Those mothers may have different perceptions of service providers than the mothers in this sample do (possibly more negative and/or fearful).

Another limitation is that the mothers in this study chose to focus on their negative experiences with service providers; however, it may be beneficial to also understand their positive experiences. Although two mothers identified service providers with whom they had a positive relationship and some mothers identified specific programs they liked, the majority of the mothers did not share positive experiences with service providers during the focus groups. This underscores the overall negative perception women may have of service providers, but it may also be due to a negativity effect or bias. Research has shown that negative often outweighs positive in terms of psychological processes (Baumeister, Bratslavsky, Finkenauer, & Vohs, 2001); specifically, negative memories or behaviors tend to be more easily recalled (Bless, Hamilton, & Mackie, 1992; Krietler & Krietler, 1968) and negative characteristics of an individual have a greater impact on impression formation than positive characteristics (Peeters & Czapinski, 1990). The dynamics of the focus groups may have also contributed to the prominently negative discussions: Mothers who had more positive experiences may not have felt comfortable sharing because they did not want to disagree with others in the group. However, the moderators encouraged all of the mothers to participate throughout the interviews and ensured all of the mothers that it was safe to share their perspective even if they disagreed with the rest of the group. Additionally, three

different focus groups were held, and the negative perceptions were consistent across all three groups.

Despite its limitations, several strengths should be noted. This is one of the few studies that queries homeless mothers' experiences with service providers. Even though the Institute of Medicine concluded that substance abuse represents the most predominant public health problem of people who are homeless, research indicates that homeless substance abusers are underserved by the system (Koegel, Sullivan, Burnam, Morton, & Wenzel, 1999). Understanding women's perceptions of the service providers within the system of care can be a first step toward overcoming this disparity. Further, the qualitative approach used in this study provides a richness of information not easily obtained through quantitative methods. That is, the participants have knowledge and understanding of their situation that cannot be fully assessed through self-report questionnaires. Finally, all women in this study were currently experiencing homelessness, and therefore, the information obtained was not retrospective and was less likely to be impacted by loss of memory or recall bias.

Conclusions

Overall, the homeless mothers in the current study reported some level of dissatisfaction with service providers. It is crucial that agencies working with homeless mothers develop ways to improve service delivery. Previous literature has found that a high portion of service providers working with homeless families do not have formal education related to social services or specialized training focused on interacting with homeless individuals or families (Lindsey, 1998b; Olivet, McGraw, Grandin, & Bassuk, 2010; Weinreb & Rossi, 1995). However, the high levels of dissatisfaction with service providers reported by the mothers indicates that it may be beneficial for programs working with homeless mothers to develop trainings for service providers to improve service delivery and in turn increase treatment engagement. Given that mothers described a strong desire to feel understood by service providers, supervisors might consider focusing trainings on increasing service providers' understanding of the homeless mothers' experiences. Although this study did not interview service providers, the perceptions of service providers provided by the women resemble descriptions of burnout. Working with homeless populations can be emotionally exhausting and stressful, and burnout among service providers may explain some of the negative attitudes and lack of support reported by mothers (Maslach & Jackson, 1981; Maslach, Schaufeli, & Leiter, 2001; Wright & Bonnet, 1997). Assessing burnout among service providers may be an important investigation in future research, especially because strategies for addressing burnout among service providers are available. For example, holding staff retreats, providing initial and continual training, and providing extra support in difficult situations are commonly noted burnout prevention strategies and may lead to improved service delivery (Olivett et al., 2010).

As this study did not assess actual treatment engagement among women, it may be beneficial for future research to examine the relationship between positive experiences with service providers and treatment engagement. Research that engages substance-abusing homeless mothers who have completed a substance abuse treatment program, or who have successfully become rehoused, may provide an important understanding of how or if interactions with service providers influenced mothers' treatment engagement and success. Finally, this study did not assess service providers' perceptions. Given the reciprocal nature of service provider–mother relationships, it may be important for future research to also examine service providers' perceptions of homeless mothers and their beliefs about service delivery.

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TABLE 1

Focus Group Questions

Past Experiences
What are your prior (negative and positive) experiences with the social system? How have you felt the social system has helped you or hurt you?
What are the issues/barriers that you face when you are accessing services?
How Mothers Hope to Be Treated
What qualities would you like to see in an advocate?
What would make you want to meet with your advocate?
If someone were to run a program where people were to help you meet some of your needs, what would that look like?
What are the personal issues that you might need help with? Are there any things that you would not want to talk about with your advocate/therapist?

TABLE 2

Themes From Focus Groups

Past Experiences			
Theme	**Original Statements**	**Agreement Statements**	**Examples**
Perception that service providers do not understand	48	13	"Ain't nobody happy to be a drug user mom … and you get treated like crap everyday."
Perception that service providers are unsupportive	52	26	"And there are other ways they can help us … they just don't want to."
Fear of service providers	24	10	"You can't tell them you use heroine … you wouldn't be able to keep your kid."
How Mothers Hope to Be Treated			
Theme	Original Statements	Agreement Statements	Examples
Desire to be understood	23	8	"I feel like if I would get an advocate that actually paid attention to me and really realized what I do think, I would feel three times much better …"
Desire for support	31	9	"I need somebody there; you need the guidance, you need the extra push, you need that pat on the back."
Trust	30	1	"You get comfortable enough with somebody; you would be almost cool to talk with them."