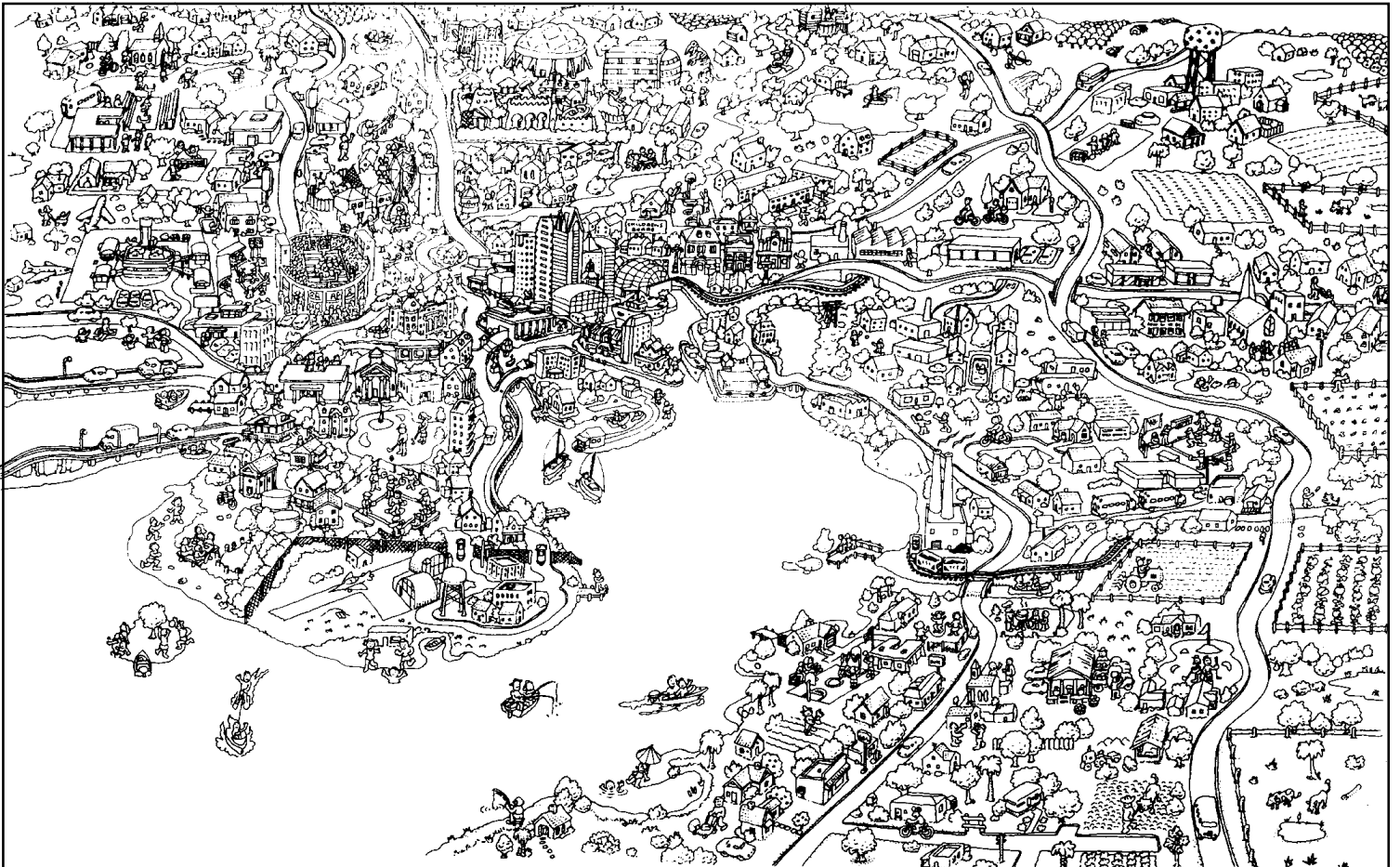


WOMEN'S SUBSTANCE ABUSE COLLABORATIVE

**WOMEN AND
SUBSTANCE ABUSE IN
HILLSBOROUGH COUNTY,
FLORIDA**



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**Written By:
Vicki S. Adelson, M.A.
The Phoenix Group
Clearwater, Florida**

**THIS REPORT WAS WRITTEN FOR THE HILLSBOROUGH COUNTY WOMEN'S SUBSTANCE
ABUSE COLLABORATIVE WITH FUNDS PROVIDED BY THE CHILDREN'S BOARD OF
HILLSBOROUGH COUNTY.**

VISION STATEMENT

We, the providers, planners, and funders of substance abuse services, envision a system of services for families affected by substance abuse, that is effective and efficient, and meets the needs of clients. We believe that the services offered by and through the desired system should be:

- Comprehensive
- Family-centered
- Collaborative
- Empowering
- Coordinated
- Holistic
- Outcome-oriented
- Culturally and ethnically sensitive
- Lead to self-sufficiency

WOMEN'S SUBSTANCE ABUSE COLLABORATIVE

Ann Ashcraft
Healthy Start Coalition
P.O. Box 18974
Tampa, FL 33679-8974

Jan Bates
Hillsborough County
Sheriff's Office
1201 E. Orient Rd.
Tampa, FL 33619

Pat Cook
Centre for Women
305 S. Hyde Park Ave.
Tampa, FL 33606

Beth Ficquette
Centre for Women
305 S. Hyde Park Ave.
Tampa, FL 33606

Bob Holm
Department of Children
& Families
4000 W. Dr. ML King Blvd.
Tampa, FL 33614

Pat Marsicano
Hillsborough County
Anti-Drug Alliance
County of Hillsborough
P.O. Box 1110
Tampa, FL 33601

Peter Plant
Tampa Crossroads
5120 N. Nebraska Ave.
Tampa, FL 33603

William Stone
Children's Board
1205 E. 8th Ave.
Tampa, FL 33605

Kathleen Avery
Salvation Army
1603 N. Florida Ave.
Tampa, FL 33602

Bonnie Christiano
Alpha House
208 S. Tampania Ave.
Tampa, FL 33609

Paul D'Agostino
Child Abuse Council
3108 W. Azelee St.
Tampa, FL 33609

Carolyn Hancock
Goodwill Industries
4102 W. Hillsborough Ave.
Tampa, FL 33614

Bill Janes
DACCO
4422 E. Columbus Dr.
Tampa, FL 33605

Jeff O'Neill
ACTS
4612 N. 56th St.
Tampa, FL 33610

Maureen Schaufauser
Chrysalis House
13716 Walbrooke Dr.
Tampa, FL 33624

ACKNOWLEDGMENTS

We are deeply appreciative for the financial support provided this project by the Children's Board of Hillsborough County. Particular thanks go to Bill Stone who attended many of our meetings, and whose advice and support was invaluable.

We also want to express our appreciation to Bob Holm, District VI Alcohol, Drug Abuse, and Mental Health Program Office, Florida Department of Children and Families as well as Ann Ashcraft, Healthy Start Coalition of Hillsborough County, both of whom provided data used to develop our profile of Hillsborough County women in treatment.

EXECUTIVE SUMMARY

The Women's Substance Abuse Collaborative was formed in mid-1996 as Hillsborough County was struggling to meet the ever-increasing need for substance abuse services for women and coping with the possibility of reductions in funding for existing programs that offered specialized services for this population. In July, the Collaborative received a grant from the Children's Board of Hillsborough County to conduct a critical issue analysis of the need for and nature of specialized treatment for women with substance abuse problems in Hillsborough County.

The purpose of the analysis, as proposed by the Collaborative, was to establish a set of recommendations that could be used by planning and funding agencies to jointly develop a continuum of services for families affected by substance abuse. The target population for the analysis was defined as "substance-abusing women of childbearing age and substance-abusing women with minor children living in Hillsborough County."

Members of the Collaborative met regularly for the past year. During this period, the issue that had originally brought together the study group, prospective reductions in funding for gender-specific substance abuse treatment programs, was pushed aside temporarily so that the group could seek the answers to such questions as:

1. What are the reasons women abuse alcohol and other drugs?
2. What are the implications for treatment?
3. What barriers prevent women from obtaining treatment?
4. What services are needed by women with substance abuse problems?
5. Are these services available for women who live in Hillsborough County and, if so, how accessible are they to Hillsborough women?

In order to answer these questions, the Collaborative conducted an extensive review of the literature on patterns, characteristics, and consequences of substance abuse by women as well as the effectiveness of different treatment approaches and services for women. Data were collected from existing sources to develop a profile of the characteristics and perceptions of women served by substance abuse treatment programs in Hillsborough County. A provider focus group was held to identify changes in the profile of women in treatment that have occurred over the past five years. A lengthy survey gathered information about publicly-funded, licensed substance abuse programs in the county that serve women.

This report, *Women and Substance Abuse in Hillsborough County, Florida*, presents the findings, conclusions, and recommendations of the Collaborative based on its work during the past year. In Section I, the background, purpose, partners, and process used to conduct the analysis are discussed. Section II contains a description of the patterns, characteristics, and consequences of alcohol and other drug usage by women in the United States as revealed by the literature. The addictive process and various treatment approaches, including alternative programs designed specifically for women, are discussed in Section III. The third section concludes with a description of the "ideal" substance abuse treatment continuum for women.

Section IV of *Women and Substance Abuse in Hillsborough County, Florida*, profiles chemically dependent women in Hillsborough County. The section contains a description of women treated for substance abuse during the 1995-96 fiscal year and recounts the experiences of a group of pregnant/postpartum women receiving treatment during the 1994-95 fiscal year. Section IV also presents the views of service providers with respect to the changing profile of women in treatment. The substance abuse treatment programs serving women in Hillsborough County are

described in Section V based on surveys completed by the programs themselves. The section compares general characteristics, service components, and the nature of the services provided by specialized programs that only serve women with nonspecialized programs that serve both men and women. This section includes a detailed list of the study group's findings with regard to the two types of programs.

In Section VI of *Women and Substance Abuse in Hillsborough County, Florida*, the study group presents its conclusions and recommendations, and identifies several outstanding issues that were not addressed during this analysis. The conclusions presented in this section support findings that in turn serve as the basis for the study group's recommendations. The recommendations should be of interest to providers, planners, and funders of substance abuse treatment services as well as all other human services that impact children and the family, and are as follows:

Recommendation 1-Nature of Program

A. Continue, modify, and establish substance abuse programs for women that offer gender-specific treatment that nurtures, empowers, and emphasizes the importance of relationships and provides family-centered, comprehensive, and coordinated services.

Recommendation 2-Treatment Capacity

A. Expand the capacity of substance abuse programs that serve women, particularly specialized programs that offer gender-specific treatment and ancillary services.

Recommendation 3-Access to Services

A. As the treatment capacity for women is increased, strive to overcome barriers to access by developing specialized outreach services designed to help women enter to treatment.

B. Specialized outreach services should present a balanced message that does not blame women for their addiction problems but instead recognizes the need for personal responsibility, communicates an understanding of the stress that women face in their daily lives, and acknowledges cultural or gender roles that contribute to or help reduce such stress.

C. Specialized outreach efforts should target the addicted woman and her support group (family, significant others, friends, co-workers). In addition, special efforts should be made to inform community groups, government agencies, public health and social service organizations, the law enforcement and criminal justice system, charities and places of worship about substance abuse programs and services that are available for women. Special efforts also should be made to reach out to child welfare workers so that substance-abusing women with children at-risk of or already in out-of-home care are able to obtain treatment.

Recommendation 4-Types of Services Needed

A. All women in treatment for substance abuse should have access to the following core and ancillary services of a continuum-of-care as listed:

- | | |
|---|-----------------------------------|
| a. Detoxification | b. Intake screening |
| c. Comprehensive assessment | d. Service planning |
| e. Case management | f. Medical assessment/care |
| g. Women's health services | h. HIV testing/counseling |
| i. Pharmacotherapy | j. Urine testing |
| k. Substance abuse education | l. Substance abuse counseling |
| m. Psychological counseling | n. Other therapies |
| o. Infant/child health services | p. Early intervention services |
| q. Home-based support | r. Life skills education |
| s. Health education | t. Transportation |
| u. Housing assistance | v. Child care |
| w. Academic education | x. Vocational/job skills training |
| y. Employment preparation/job placement | z. Continuing care |

Recommendation 5-Collaboration

A. Planners and funders of substance abuse treatment and ancillary services needed by women during and after treatment should address the need for improved service networking, communication links, and coordination by facilitating changes that make it easier for providers to work together.

B. The providers of substance abuse treatment for women should:

- Develop a mechanism to facilitate networking in the provider community;
- Maintain linkages with the providers of ancillary services needed by women during and after treatment; and
- Maintain linkages with planners and funders of substance abuse treatment and ancillary services to communicate the need for these services.

Recommendation 6-Service Planning and Funding

A. Local planners and funders of human services should develop a community strategy to prioritize existing and anticipated needs for substance abuse treatment and ancillary services for women across all service delivery systems.

B. The community strategy should support the funding of substance abuse treatment and ancillary programs and services for women that:

- Promote health, wellness, and responsible adult roles for women;
- Support the stability and functioning of families;
- Build the resiliency of children and youth so they are able to maintain a healthy drug-free lifestyle and perform well in school; and
- Provide, either directly or indirectly, services that enhance parenting skills,

facilitate child development, and deter relapse and prevent substance abuse by their children.

C. Having established a community strategy, local funders and planners of human services should encourage use of the strategy for funding substance abuse treatment and ancillary programs and services needed by Hillsborough women during and after treatment.

TABLE OF CONTENTS

VISION STATEMENT	i
MEMBERS OF STUDY GROUP	ii
ACKNOWLEDGEMENTS	iii
EXECUTIVE SUMMARY	iv
TABLE OF CONTENTS	viii
I. INTRODUCTION	1
Background	
Purpose	
Partners	
Process	
II. CHARACTERISTICS OF USAGE	5
Alcohol	
Other Drugs	
Related Issues	
III. TREATMENT MODELS	13
Medical-Based Approach	
Traditional Recovery Services	
Alternative Programs for Women	
CSAT Comprehensive Treatment Model	
Nature of Services	
Barriers to Treatment	
IV. WOMEN IN TREATMENT	29
Characteristics	
Perceptions of Women in Treatment	
Changing Profile	
V. TREATMENT PROGRAMS	39
General Survey Findings	
Service Components	
Nature of Services	
VI. CONCLUSIONS, RECOMMENDATIONS, AND ISSUES	45
Conclusions	
Recommendations	
Outstanding Issues	
Final Comments	
REFERENCES	55

I. INTRODUCTION

BACKGROUND

When the Women's Substance Abuse Collaborative was formed in late 1996, Hillsborough County was struggling to meet the ever-increasing need for substance abuse services for women and coping with the possibility of reductions in funding for existing programs that offered specialized services for this population. Publication of *A Community Call to Action* by the Children's Board of Hillsborough County the previous winter brought to the fore the issue of "sunsetting" (i.e. the termination of program funding, despite satisfactory performance, after three years) with regard to these programs. The reduction in funding, if implemented, would have had a detrimental effect on the few programs in the community that provided specialized services for women. Not only was the Children's Board the only source of funding for many of the ancillary services (i.e. child care, transportation, supported housing) provided by these programs for women, but the funds were used both as match for federal block grant funds and to provide services required in order to continue receiving certain federal funds set-aside for women.

The threatened reduction in Children's Board funding brought together the providers of substance abuse services for women. A group of providers developed a proposal, which was recommended for funding in July as a critical issue analysis by the Human Service Work Group. Funding of the proposal by the Children's Board enabled the providers to hire a consultant, The Phoenix Group, to facilitate and staff the analysis. By September, a study outline was written and a study group consisting of providers and funders of substance abuse treatment and related ancillary services formed. Known as the Women's Substance Abuse Collaborative, the study group for the analysis met regularly for the past year and diligently reviewed the materials brought before it by the consultant. This report, *Women and Substance Abuse in Hillsborough County, Florida*, represents the findings, conclusions, and recommendations of this group.

During the past year, the issue that originally brought together the study group, prospective reductions in funding for gender-specific substance abuse treatment programs, was pushed aside temporarily so that the group could seek the answers to such questions as:

1. What are the reasons women abuse alcohol and other drugs?
2. What are the implications for treatment?
3. What barriers prevent women from obtaining treatment?
4. What services are needed by women with substance abuse problems?
5. Are these services available for women who live in Hillsborough County and, if so, how accessible are they to Hillsborough women?

As the study group coalesced around these five issues, the project took on new meaning. Providers, planners, and funders alike became less concerned about "who should fund what services and at what level" and instead concentrated on "why and what services were needed." By removing the issue of funding from the table, the study group was able to develop a "shared vision" of what services ought to be available for women in Hillsborough County. The next task is to further define the services that are needed and to describe alternative ways of providing these services given the fiscal realities of the 1990s.

PURPOSE

The funding for this critical analysis was provided by the Children’s Board of Hillsborough County based on the premise that there was a need to determine the necessity for and nature of specialized treatment for women with substance abuse problems in Hillsborough County. The purpose of the analysis was to establish a set of recommendations that could be used by planning and funding agencies to jointly develop a continuum of services for the families affected by substance abuse. The “target group” for the analysis was defined as “substance-abusing women of child-bearing age and substance-abusing women with minor children who live in Hillsborough County.” Consistent with this purpose, the objectives of the analysis were to:

1. Describe existing substance abuse services relative to the target population.
2. Describe desired substance abuse services relative to the target population.
3. Identify differences between existing and desired substance abuse services relative to the target population.
4. Develop recommendations for treating women in the target population.

PARTNERS

The study group for the analysis consisted of (1) agencies that receive public funds to provide substance abuse treatment and ancillary services for the target population (Agency for Community Treatment Services, Alpha House, Centre for Women, Child Abuse Council, Chrysalis, Drug Abuse Comprehensive Coordinating Office, Goodwill Industries, Hillsborough County Sheriff’s Office, Salvation Army, and Tampa Crossroads) and (2) organizations that provide public funding for these agencies (Anti-Drug Alliance/County of Hillsborough, Children’s Board of Hillsborough County, Department of Children and Families’ Alcohol, Drug Abuse and Mental Health Program Office, and the Healthy Start Coalition of Hillsborough County).

A steering committee composed of the Agency for Community Treatment Services, Centre for Women, Child Abuse Council, Drug Abuse Comprehensive Coordinating Office, and Tampa Crossroads interfaced with the project consultant on behalf of the study group. In this role, the steering committee performed a number of vital functions including: facilitating consultant access to information and key persons within the system; assisting the consultant to resolve various problems and issues; reviewing each section of the report before presentation to the study group; and ensuring that the project moved towards completion within a realistic and reasonable time frame. In addition, all meeting notices and mailings were handled by the steering committee.

PROCESS

The study group and the steering committee met regularly throughout the past year. Both groups were facilitated by the project consultant who also was responsible for preparing the agenda and materials for each meeting. The original study outline was modified by the consultant and the study group in response to various conditions as the analysis progressed.

The project consultant conducted a literature search regarding the patterns, characteristics, and consequences of substance abuse by women as well as the effectiveness of different treatment approaches and services for women. This information was summarized and presented in writing to the study group.

Data were collected by the project consultant from existing sources to develop a profile of the characteristics and perceptions of women served by substance abuse treatment programs in Hillsborough County. In addition, a provider focus group was held to identify changes in the profile of women in treatment that had occurred over the past five years. The consultant summarized this information in writing and presented it to the study group.

A survey was developed by the project consultant to gather information about substance abuse programs serving women in Hillsborough County. Based on the results of the literature search and profile, the survey was refined by the steering committee. After the survey was reviewed by the study group, it was distributed to all publicly-funded, licensed substance abuse programs in the county that served women.

The results of the completed surveys were compiled by the project consultant. The survey results were then analyzed by the steering committee. The findings of the steering committee were presented to the study group, which suggested various areas for further analysis. A list of conclusions and recommendations was developed by the consultant based on a review of the findings and input from the steering committee. The remaining sections of the report were then drafted by the consultant.

Two meetings of the study committee were held to review the report and recommendations as drafted by the consultant. Based on input received at these meetings, the report and recommendations were revised for submission to the Children's Board.

II. CHARACTERISTICS OF USAGE

Until recently, it was assumed that while less women abuse alcohol and other drugs than men, the patterns of usage, psychological characteristics, and physiological consequences of substance abuse were identical for both women and men. In fact, substance abuse is more widespread among women than originally believed and, although there are some similarities in the patterns, characteristics, and consequences of substance abuse between women and men, there are also many critical differences.

While it is true that more men than women abuse alcohol and other drugs, the “gender gap” is closing. According to the authors of *Substance Abuse and the American Woman* (CASA, 1996), one in five women in the United States (as opposed to one in three men) now abuse or become dependent on alcohol and/or other drugs at some point in their lives. As this “gender gap” closes, it becomes ever more important that women, their husbands, families, doctors, and treatment professionals learn more about how to prevent and treat substance abuse.

The actual number of substance-dependent women in this country is difficult to determine “given their frequent isolation . . . and, more frequently, the tendency of society and health care providers to deny or overlook the problem” (Abbott, 1994). National surveys and research reports based on statistics produced by treatment programs serve as the basis for most of the information that is gathered. The reliability of both sources is questioned by some authorities; the former because they are based on self-reported usage, and the latter because they depend on the availability of appropriate treatment programs for women (Abbott, 1994).

ALCOHOL

Heavy drinking appears to be far more widespread among women than some national studies would suggest. The 1993 National Household Survey on Drug Abuse (NHSDA), for example, found that 2.5 million or 2.6 percent of the 40.5 million women living in the United States have at least 60 drinks a month — the measure of heavy drinking established by the National Institute of Alcohol Abuse and Alcoholism (CASA, 1996). That measure, however, is based on the male standard for heavy drinking: two drinks a day.

The National Institute of Alcohol Abuse and Alcoholism reports a 2:1 ratio of male to female problem drinkers, with approximately 14 percent of adult males and 6 percent of adult females being alcohol abusers or dependent on alcohol (Abbott, 1994). These figures are consistent with those found by Hilton and Clark (1987) for the seventeen years between 1967 and 1984. Recent studies, however, suggest that an increase in problem drinking among younger women may be causing these gender differences to converge (Weisner & Schmidt, 1992).

Numerous studies have documented the patterns, psychological characteristics, and physiological consequences of alcohol usage by women in the United States. In a comprehensive survey of the literature, the authors of *Substance Abuse and the American Woman* (CASA, 1996) found that:

Patterns of Use

- The proportion of women who drink heavily changes little with age; however, since tolerance decreases over time, alcoholism may be more prevalent among elderly than younger women.
- Women with lower incomes are more likely to drink heavier. For example, women with incomes below \$15,000 are twice as likely to be heavy drinkers as women in households with higher incomes.
- With the exception of binge drinking, heavy drinking rates decline as education levels increase. Binge drinking is more common among women college students.
- White women are more likely to drink than African-American women, but their rates of drinking differ only slightly.
- Relatively few Asian-American or Hispanic women do any heavy drinking, while a disproportionate number of Native American women have drinking problems.
- Working women are 67 percent more likely to drink heavily than homemakers; a working woman who is unemployed is four times more likely to drink heavily than a working woman who is employed.

Psychosocial Characteristics

- Women who drink heavily are more likely to have a partner who drinks heavily.
- Women who have never married, particularly those living with a partner, are 50 percent more likely to drink heavily than married women.
- Heavy drinking often subsides when women with alcohol problems divorce, while drinking often increases when women without alcohol problems divorce.
- Widows are three times more likely to drink heavily than married women.
- Women alcoholics are more likely than men alcoholics to have a family history of alcoholism.
- The results of the limited research that has been conducted on women are somewhat inconsistent, but suggest that genetics may play a role in alcoholism among women.
- Alcoholic women are more likely to have been beaten or sexually abused than non-alcoholic women or alcoholic men.
- About half of the alcoholic women who report being sexually abused have been the victims of incest.
- Alcoholic women are more likely than non-alcoholic women to have been beaten recently by a partner.

❖ Alcoholic women are more likely than alcoholic men to have a mental health disorder in addition to their alcoholism.

Physiological Consequences

❖ Women feel the physical effects of alcohol, become addicted, and develop alcohol-related illnesses, i.e. liver damage, hypertension, anemia, malnutrition, peptic ulcers, brain and heart damage, more rapidly than men.

❖ Heavy drinking impairs learning, memory, abstract thinking, problem-solving, perceptual-motor skills, and the ability to analyze spatial relationships; these impairments affect women after fewer years of drinking than men.

❖ Women alcoholics are twice as likely to die as male alcoholics in their same age group and a greater percentage die from alcohol-related accidents, violence, and suicide; the lives of women alcoholics are shorter than women in the general population by an average of 15 years.

❖ A woman's endocrine system can also be affected by heavy drinking, leading to menstrual irregularities, amenorrhea, infertility, and early menopause.

❖ Compared to non-drinkers, the risk of spontaneous abortion during the second trimester is twice as high for women who have one to two drinks daily.

❖ The infant mortality rate for women who do not drink during pregnancy is 8.6 per 1,000; it increases to 13.3 per 1,000 among women who drink while pregnant and to 23.5 per 1,000 among women who drink an average of two or more drinks per day.

❖ The risk of death is increased by more than 50 percent during an infant's first year if the mother drank heavily while pregnant.

According to the Office of Substance Abuse Prevention (OSAP, 1992), alcoholism can cause fetal alcohol syndrome (FAS), fetal alcohol effects (FAE), or alcohol-related birth defects (ARBD).¹ The reported rate of FAS increased from 1.0 per 10,000 births in 1979 to 6.7 in 1993; the latest estimate is 19.5 per 10,000 births. It is believed that the number of FAE and ARBD children is more than triple the number of children with FAS.

¹ Fetal alcohol syndrome (FAS) is the most severe condition, other than fetal death, that can be caused by the ingestion of alcohol during pregnancy. FAS is comprised of growth retardation, central nervous system damage, and congenital anomalies including facial deformities, and is the most frequent cause of mental retardation in this country. Less severe effects of alcohol ingestion are classified as fetal alcohol effects (FAE) or alcohol-related birth defects (ARBD). Children who have no outward signs of FAS, FAE, or ARBD may have behavioral, cognitive, and developmental problems. Children suffering mental retardation from alcohol use by their mothers display alarming amounts of physiopathology and maladaptive behavior (OSAP, 1992).

OTHER DRUGS

According to recent estimates made by the Alcohol, Drug Abuse, and Mental Health Administration, 697,500 or 1.5 percent of women in the United States abuse or depend on nonalcoholic illicit psychoactive drugs (Goldberg, 1995). The authors of *Substance Abuse and the American Woman* found that 3.1 million or 7.7 percent of the women living in this country regularly use illicit drugs and an additional 3.5 million or 8.6 percent regularly misuse prescription drugs. While there is a wide gap between these figures, others were not cited in the literature.

The patterns of use, psychosocial characteristics, and physiological consequences of drug addiction among women are discussed in many studies. Several articles are especially helpful in this regard, particularly one by Lani Nelson-Zlupko, Edna Kauffman, and Martha Morrison Dore (1995). According to this article, *Gender Differences in Drug Addiction and Treatment: Implications for Social Work Intervention with Substance-Abusing Women*, current research indicates that drug-dependent women differ from their male counterparts in several significant ways:

Patterns of Use

- ◆ Women are more likely than men to abuse prescription drugs and to obtain these drugs from legitimate sources.
- ◆ Women tend to abuse multiple substances more frequently than men.
- ◆ Women are more likely than men to use drugs in isolation and in private places, usually at home.
- ◆ Women are more likely to begin using drugs after a specific traumatic event in their lives, with incest and rape frequently cited as precipitating events.
- ◆ Other traumatic events reported as precipitating heavy drug use in women include sudden illness, accidents, and disruptions in family life.
- ◆ The emergence of forgotten or repressed memories and even flashbacks of such events also are reported to have triggered heavy drug use and/or relapse.

Psychosocial Characteristics

- ◆ Women are more likely than men to come from disrupted families in which drugs were used as a primary coping strategy by one or more family members.
- ◆ Women often have a history of over-responsibility in their families of origin due to death or desertion.
- ◆ Women are more likely than men to have been sexually assaulted or physically abused. Indeed, rates as high as 75 percent for sexual assault and physical abuse are reported by women in treatment.
- ◆ Women are more likely than men to be in relationships with partners or spouses who use drugs.
- ◆ Women are more likely than men to have primary responsibility for child care and the care of others in their families.

- ❖ Women are less likely to be actively supported in treatment by family members.

- ❖ Women tend to experience affective disorders more often than men. They generally experience more guilt, shame, depression, and anxiety about their addiction than do men.

- ❖ Women report more negative feelings about their bodies and are more at risk for eating disorders than men.

- ❖ Women are more likely than men to become involved with the legal system over civil matters, i.e. child custody, separation and divorce, and landlord-tenant disputes, than criminal actions.

- ❖ Women who support their habits through criminal activities are more likely than men to be involved in shoplifting and prostitution.

- ❖ Drug-dependent women usually have lower expectations for their lives than their male counterparts, probably because they have less education, marketable skills, work experiences, and financial resources.

- ❖ Women who enter treatment are more likely than men to be unemployed and to have not been employed within the past year.

- ❖ Women are more likely than men to be dependent on a family member or public assistance for financial support.

Physiological Consequences of Drug Use

- ❖ Physically, the negative consequences of drug use are greater at lower doses and in a shorter length of time for women than men.

- ❖ Women who abuse drugs are known to get “sicker quicker,” and to have higher levels of fatty liver, hypertension, anemia, and gastrointestinal disorders.

- ❖ Women addicts are at high risk of contracting HIV/AIDS.

- ❖ Women experience a number of reproductive and gynecological problems as a result of drug abuse, including sexually transmitted diseases, infertility, repeat miscarriages, and premature delivery.

According to the OSAP (1992), little is known about the effects of single drugs or combinations of drugs other than alcohol on the fetus. Studies have only recently begun to identify the effects of specific drugs and/or combinations of drugs. Infants born to heroin-dependent mothers, for example, have been found to have a high incidence of central nervous system disorders, including postnatal growth deficiencies, microcephaly, neurobehavioral problems and sudden infant death syndrome. Infants exposed to cocaine experience obstetrical complications, low birthweight, smaller head circumference, abnormal neonatal behavior, and cerebral infarction at birth, and tend to be easily distracted, passive, and to have a variety of visual-perceptual and fine motor skill problems, often displaying problems with learning and concentration, hyper-irritability, and developmental delays.

RELATED ISSUES

As indicated, substance abuse is more widespread among women than originally believed and, although there are some similarities in the patterns of usage, psychological characteristics, and physiological consequences of substance abuse among women and men, there are also many important differences. Although more men than women abuse alcohol and other drugs, the gender gap is closing. Because most women who abuse drugs are mothers, the problem affects two generations: the women themselves, many of whom are the children of substance abusers, and their drug-exposed children.

Infants must be able to communicate their needs, detect communication signals from the mother, and modify their behavior in response to those signals. Mothers must be able to read these communications and respond appropriately, providing a suitable environment. Substance abuse can interfere with this process. Drugs upset the infant's physiology; an infant in withdrawal is incapable of communicating its needs in an organized way. Drug use also interferes with the mother's "capability for, or interest in, responding to her infant's needs and building successful mother-infant communication" (OSAP, 1992).

A woman may be charged with drug crimes for using substances potentially harmful to her unborn baby. In many states, the infant of a woman known through history or urine testing to have abused a substance during pregnancy automatically comes under the jurisdiction of protective services. Although criminal charges are rare, the law presumes that a mother who abuses substances is guilty of child abuse or neglect (Goldberg, 1995). The mere existence of these laws prevents many women from seeking treatment.

In fact, substance abuse increases the risk of child abuse by about five times and neglect nine times; alcohol abuse is a significant factor in sexual abuse of children (CASA, 1996). All of the children in a study of 200 addicted parents were abused or neglected to some degree; nearly one-third (30.5 percent) were seriously neglected; and nearly a quarter (22.5 percent) were physically or sexually abused (CASA, 1996). Substance-abusing mothers are easily frustrated at the irritability of their children, many of whom are suffering from the effects of prenatal exposure to alcohol and other drugs, and consequently are at high risk of becoming abusive or neglectful parents (OSAP, 1992).

The number of referrals made to the child protective services (CPS) for suspected abuse or neglect increased nationally by 10 percent between 1988 and 1989 (OSAP, 1992). Of the 900,000 cases that were confirmed, approximately 675,00 or 75 percent involved a chemically dependent caretaker (Daro et al., 1990). A 29 percent increase was experienced in the number of foster care placements between 1988 and 1990, with most of this increase occurring in communities hardest hit by crack cocaine (Besharov, 1990). More children are in need of out-of-home care because of the "increase in CPS referrals, the complexity of CPS cases, and the lack of community alcohol and other drug treatment and aftercare resources and family support services" (OSAP, 1992).

In the past ten years, parental drug involvement has become a primary reason that children enter the child welfare system (Mangano, 1990). In some cities, such as New York, substance abuse is a significant factor in more than 75 percent of child welfare cases (CASA, 1996). Drug-exposed infants, toddlers, and preschoolers endangered by substance-abusing parents are the fastest growing population in foster care (OSAP, 1992). Infants known to be prenatally drug-exposed are likely to have contact with the child welfare system, and it is estimated that as many as 80 percent of all identified drug-exposed infants of untreated chemically dependent mothers will be placed in foster care during their first year of life (OSAP, 1992).

According to the OSAP (1992), anecdotal evidence strongly suggests that "chemical dependency plays a significant role in debilitating families and making

reunification efforts far more difficult.” Crack cocaine, in particular, has exacerbated problems identified in earlier studies that found “children of alcohol- or drug-involved parents stayed in foster care longer than any other population, were moved around more frequently, and were less likely to return home to parents . . . more difficult to plan for, in large part because of the parents’ inability to become an active participant in the planning process.”

Noninvestigative child welfare services in many states have been placed in jeopardy by the increased demand for child protective services. Resources for prevention, intervention, treatment and family support services, in short supply before drug problems escalated, are even more scarce today. Still, says OSAP (1992), the child welfare system must attempt to address the needs of chemically dependent parents, assess the threat chemical dependency poses to the safety and welfare of the young child, and intervene to protect the child when necessary.

The children of substance-abusing mothers often are raised in environments best described as “unfortunate.” Frequently, these children are raised by only one parent and live in low-income, high crime areas where they are exposed to violence and crime when very young. The illicit drug use of their mothers often leads to a deviant, if not criminal, lifestyle. Separations resulting from periods of incarceration may further contribute to the disrupted family life experienced by these children. The impact of these problems on nondisabled children would be significant; their impact on vulnerable, drug-exposed children is even greater (OSAP, 1992).

The OSAP (1992) believes that child welfare agencies must “attempt to undo the physical, mental, and developmental problems that affect toddlers and preschoolers who have been prenatally or environmentally exposed to alcohol and other drugs.” In addition, they must also “intervene on behalf of the family and attempt to repair the dysfunctional patterns that contributed to child maltreatment, including chemical dependency. Many of these families, notes OSAP, are “headed by single females, who are marginally coping, frequently living in poverty, and often unable to offer consistent care for and supervision of their children.”

III. TREATMENT MODELS

According to the Center for Substance Abuse Prevention (CSAP, 1993), medicine formally recognized addiction as a primary disease toward the end of the twentieth century. A variety of approaches are used to treat alcohol and other drug dependencies. Each approach brings with it a unique perspective.

MEDICAL-BASED APPROACHES (MEDICAL MODEL)

The field of addiction medicine has led to the development of medical-based approaches to treatment. Such approaches use a variety of medically assisted or monitored treatment methods. Unlike traditional recovery programs, many patients enter medical-based treatment programs out of necessity, i.e. severe alcohol or heroin withdrawal. Treatment may take the form of admission to a hospital inpatient unit or a specialized chemical dependency recovery hospital. Once admitted, medical specialists provide pharmacologic and non-pharmacologic interventions, and help patients understand the progressive nature of their disease. Recognizing that medications deal with only one aspect of the disease, many medical-based treatment programs combine this approach with elements of traditional recovery services.

TRADITIONAL RECOVERY SERVICES (SOCIAL SERVICES MODEL)

Most addiction treatment programs in the United States use a “social/community model” approach that includes behavior therapy, 12-step groups such as Alcoholics Anonymous, education, recognition of spiritual needs, and peer support (CSAP,1993). These programs are often referred to as “traditional recovery services.”

Traditional recovery services (TRS) are considered to be very successful in facilitating recovery. The “12-step approach” used by these programs refers to specific stages of recovery that, according to the CSAP (1993), are “based on individuals’ acceptance of the nature of the disease and their powerlessness to control their lives.” The 12 steps are based on the belief that “alcoholics have spiritual and physical powers that can overcome the effects of their disease despite having lost control over their biology . . . that a *higher power* (which can be whatever the individual chooses) will guide the alcoholic through recovery.”

In the 12-step approach, recovery is the responsibility of the individual with the support of a higher power. According to the CSAP (1993), the thought of a higher power gives some recovering alcoholics and addicts the inner strength they need to “grow and heal.” The 12-step approach, notes CSAP, has been shown to work well both “alone and within the context of other psychotherapeutic and addiction treatment programs.”

ALTERNATIVE PROGRAMS FOR WOMEN

The major problem with traditional recovery services is intrinsic to their design (CSAP, 1993). That is, “they have been principally fashioned to meet the challenges of chemical dependency in men and do not address women’s issues.” According to the CSAP:

Traditional recovery approaches, especially the 12-step model, are based on “male alcoholism” (Covington, 1991). The traditions of recovery are designed to deal with the male sense of grandiosity and expanded ego. Programs are very directive at first as they try to chip away at the client’s ego. They are based on the confrontational model. Women are often

“programmed” differently from men, and the approach of confronting self-esteem and ego may not be appropriate for women early in recovery.

CSAP (1993) recommends that addiction professionals “reformulate” prevention and treatment efforts for women “within a more comprehensive, coordinated, family-centered or relational approach.” Treatment services for women should be *family-centered*, i.e. address the mother-child unit as well as the woman’s partner and family; *comprehensive*, i.e. provide all the services needed by these women and their children; and *coordinated*, i.e. draw together multiple services, with direct collaboration among providers where possible.

In recent years, many alternative programs have been developed that are designed specifically for women. These specialized programs offer gender-specific treatment, which focuses on the woman’s strengths and use her experiences, both past and present, as learning tools. In alternative programs, emphasis is placed on the concept of the use of alcohol and other drugs as a coping mechanism. That is, to the idea that women use alcohol and other drugs to cope with what appear to them to be insurmountable stressors in their lives.

This theory, explains Nelson-Zlupko et al. (1995), means that while chemical use may actually succeed for a short time as a coping mechanism for a woman; at some point, it becomes apparent to the woman that the negative effects of alcohol or drug use outweigh its benefits. Unfortunately, even though the woman may realize that this method of coping is no longer reliable or effective for her, she continues to use alcohol or drugs because she is unable to identify any positive options. In alternative programs, women identify aspects of the environment that are unhealthy for them in that they “trigger” the use of alcohol and other drugs and are “helped to develop and use effective, safe, and nondestructive alternative coping strategies.

CSAT COMPREHENSIVE TREATMENT MODEL

Historically, substance abuse has been identified as a male problem, and existing treatment programs have been developed with this in mind (Abbot, 1994). Because most treatment programs have been designed for and are largely attended by males, research findings used to guide further program development are based primarily on male subjects and their experience. As a result, many treatment programs do not adequately take into account physiological, psychological, and treatment differences and risk factors between males and females in the development of service options.

The authors of *Implementation of a Family-Centered Treatment Program for Substance-Abusing Women and Their Children: Barriers and Resolution* (Metsch et al., 1995), believe that consensus is growing in the field that “the fundamental focus of traditional programs needs to be modified and reoriented for women.” This means, says Metsch et al., that:

- More aggressive outreach strategies need to be adopted;
- Appropriate ancillary services need to be provided;
- Relapse prevention plans and aftercare programs need to be developed;
- The therapeutic approach needs to be changed, i.e. counseling styles, gender ratios, cultural sensitivity; and
- More studies need to be conducted about factors that contribute to substance abuse among women and their implications for treatment.

According to the Center for Substance Abuse Treatment (CSAT, 1994), a woman's substance abuse must be addressed in the context of her health and her relationship with her children and other family members, the community, and society. The findings of current studies support the views expressed by CSAT in that they suggest that in order to treat substance-abusing women successfully, programs must "attend to the full complexity of their lives, rather than focusing solely on addiction" (Kauffman et al., 1995).

Treatment programs must offer women a continuum of services, both internal and external, from outreach through continuing care. Not only must these services be family-centered, comprehensive, and coordinated (OSAP, 1993), but they also must be *integrated* with and not duplicative of other services within the larger community that are needed by recovering women (CSAT, 1993). The interrelationships between the treatment program and the community, as envisioned by CSAT are depicted in Figure 1.

INTERRELATIONSHIPS BETWEEN TREATMENT PROGRAM AND COMMUNITY

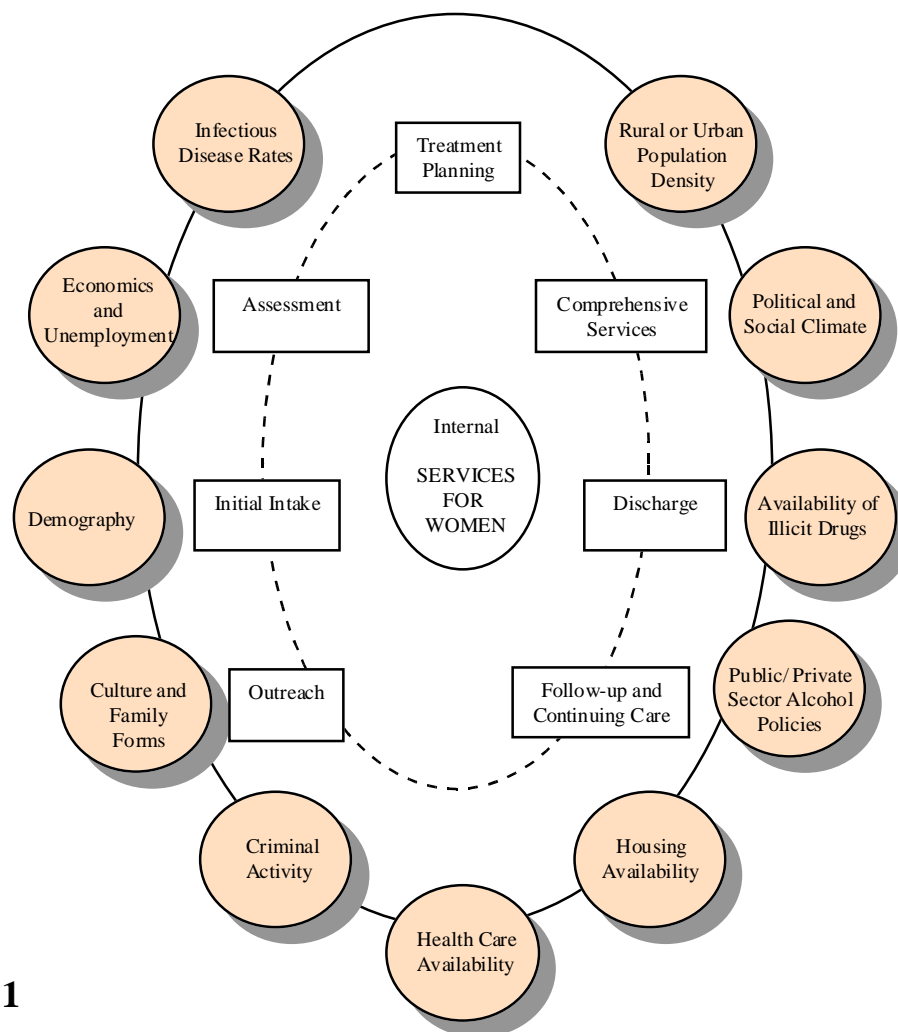


Figure 1

The comprehensive treatment model, developed by CSAT, is based on the premise that successful substance abuse treatment for women must be a part of a broad public health and social services response. CSAT's comprehensive treatment model, described in a 1994 publication entitled *Practical Approaches in the Treatment of Women Who Abuse Alcohol and Other Drugs*, consists of three closely interconnected stages of care:

- Outreach;
- Comprehensive treatment; and
- Continuing care.

Together, the stages of care constitute an “ideal treatment continuum” that CSAT believes should be in place regardless of the treatment modality that is selected.

1. OUTREACH

According to CSAT, designing successful outreach programs for women requires an understanding of basic social marketing principles including how to define the product; create an effective message; and deliver the message to the target audience. Trained outreach workers and community contacts are essential for a successful outreach effort. Even more important, however, are comprehensive services designed to meet women's needs.

CSAT recommends that programs hire outreach workers who are familiar with the community in which they work, both geographically and culturally; understand and are sensitive to the reality of women's lives and the issues substance-abusing women face; understand the process of addiction and agree with the program's philosophy; convey respect and support for women; and are able to describe the opportunities offered by the program in concise, understandable terms. In addition, workers who interact with women during pregnancy should also be sensitive to the different ways that pregnancy is viewed by individual women.

Three different options, says CSAT, are available for staffing outreach programs. First, existing program staff could be trained in outreach techniques. Second, a former client or community resident who is a trained outreach worker and has experience in or knowledge of substance abuse could be hired. Or, third, a contract could be developed with a community-based organization that already has trained outreach workers in the community. CSAT recommends either of the latter two options.

CSAT suggests that programs in the process of deciding how to conduct outreach activities should:

- Assess the resources that are available, both human and financial.
- Collect and analyze available demographic data to form an accurate picture of the extent and nature of substance abuse problems among various groups of women in the community.
- Take the steps necessary to ensure that the program's advisory committee, board of directors, and staff include representatives of the target population. If necessary, provide training for committee, board, and staff members to ensure that those individuals understand the impact of substance abuse on women.

- Solicit ideas about how to reach the target population from health, mental health, disability/rehabilitation, legal, and social service personnel in the community as well as women in recovery and program staff who are in contact with the target population.
- Examine the language that the program uses to ensure that it helps women understand addiction as a health issue; does not reinforce low self-esteem or powerlessness; does not further stigmatize women by insinuating that addiction is a moral failure.
- Make sure that the program is accessible to the target population — architecturally, economically, geographically, and culturally — and that the services it advertises are indeed available and responsive to the needs of women.

According to CSAT, a balanced message should be presented that does not blame women for their addiction problems, but instead recognizes the need for personal responsibility. Materials should communicate an understanding of the stress that women face in their daily lives and acknowledge cultural or gender roles that contribute to or help reduce such stress. Women should be informed that there are ways to reduce and cope with stress, including understanding the factors over which they have no control.

Printed materials should describe the program’s services in culturally sensitive, easy to read language that is relevant to the women targeted for services. Illustrations should be used frequently. The materials should be published in Spanish and other languages used by targeted women. CSAT believes that one-on-one personal contact is the most effective way to encourage substance-abusing women to enter treatment. Such contacts can be made in a multitude of formal and informal ways.

CSAT recommends that special efforts be made to educate community groups and government services agencies about the program. Public health and social services, community-based programs for women, the criminal justice system, charitable organizations, and places of worship should be contacted regularly. The message also must reach the substance-abusing woman’s support group (family, significant others, friends, coworkers) and social systems (spiritual leaders, shelter personnel, law enforcement officers, physicians, pharmacists, visiting nurses, teachers, home health care workers, probation and corrections officers) who can be a major source of referral for the program.

Special efforts, says CSAT, also need to be made to reach out to child welfare workers so that substance-abusing women with children at-risk of or already in out-of-home care are able to obtain treatment. Child welfare workers frequently encounter these women through protective services. Such workers often are angry and frustrated with women who abuse drugs at the expense of their child’s safety and well-being, and try to motivate them to obtain treatment by threatening them with the loss of their children. Given the evidence that traditional treatment programs fail to meet the needs of women and their high drop-out rates, it is important that child welfare workers be aware of alternative programs in the community that address the special needs of addicted women.

According to CSAT, some substance abuse treatment programs exclude women who are or could potentially be involved with a child protective services agency. Until this situation changes, treatment will remain unavailable for most substance-abusing women. CSAT believes that women should not be barred from treatment or discriminated against because they are mothers. Recognition must be given to the fact that the “family circumstances for these women may need to be fluid, rather than

static.” That is, that children may be periodically absent and subsequently return to the home. CSAT recommends cross-service training of substance abuse treatment staff and child welfare workers in order to promote a better understanding of the issues common to both groups and to promote a strong working relationship between the two groups.

2. COMPREHENSIVE TREATMENT

CSAT’s model comprehensive treatment program was developed in order to foster the establishment of “state-of-the-art recovery for women with alcohol and other drug dependencies, and to foster the healthy development of the children of substance-abusing women” (CSAT, 1994). The purpose of comprehensive treatment, according to CSAT, is to “address a woman’s substance abuse in the context of her health and her relationships with her family, community, and society.” The model is intended to serve as a guide that communities can adapt and use to build comprehensive programs over time.

Services

Developing an effective response to the alcohol and other drug problems of women requires the coordinated delivery of all necessary services. Figure 2 depicts the services that CSAT recommends be provided either on-site or through referral as part of the comprehensive treatment process for women.

Modalities of Care

Treatment modalities can be classified in many ways. The classifications used most often to categorize treatment modalities are: setting, i.e. outpatient, day treatment, residential; length of care, i.e. short-term or long-term; and philosophical approach, i.e. medical model or social services model. When treatment modalities are classified by setting, they are usually arranged on a continuum. Most commonly, the continuum looks like this:

- (1) Inpatient detoxification to residential treatment and rehabilitation to outpatient or intensive day treatment and continuing care, or
- (2) Residential treatment to outpatient rehabilitation and continuing care.

According to CSAT, research has demonstrated that no single setting is effective for all individuals and that clients may experience varying degrees of success with different settings or combinations of settings at different times. CSAT defines each of these treatment settings as follows:

- Inpatient detoxification programs are designed to facilitate the client’s safe withdrawal from drugs. Services usually include intensive client counseling to encourage further treatment and referral to appropriate programs for continuing care. Detoxification programs usually last from one to seven days; however, they may last longer for women withdrawing from addictive prescription drugs, pregnant women, women who present medical risks or have co-occurring disorders.
- Residential rehabilitation programs are provided to individuals who need treatment services in a controlled and structured environment over a longer period of time. Services can include nursing care; individual, group, and family counseling; physical examinations, including laboratory tests;

psychiatric evaluations; and provision of medications. Some programs also include more comprehensive services such as employment counseling, referral for primary health care and social services, and referral of pregnant women for prenatal services.

- Outpatient or intensive day treatment programs provide services which vary widely both in terms of intensity and length. Services usually include individual, group, and family counseling; employment counseling; and referral for health (medical and mental) and social services not provided directly by the treatment program. These programs are affiliated with inpatient programs and provide continuing care services.

3. CONTINUING CARE

CSAT (1994) believes that alcoholism and other drug dependencies are “chronic, progressive disorders often characterized by relapse.” CSAT considers continuing care to be an “essential component of substance abuse treatment for women.” According to CSAT, continuing care “involves activities that support long-term rehabilitation and prevent relapse of female clients who have completed specific substance abuse treatment programs.” Continuing care services include case management; the development of relapse prevention skills; assistance accessing and developing skills to access needed services; and facilitation of entry into relevant education and job training programs.

Case Management

Case management, says CSAT, should continue to be provided during continuing care, preferably on a weekly basis, in order to help women to continue services initiated during the intensive phase of treatment. During continuing care, the case manager should continue to assist women obtain benefits and entitlements; access health care services, housing, child care, and transportation; and coordinate appointments with various service providers. The case manager also should assess the woman’s progress, identify those who have relapsed or are in danger of relapsing and, if necessary, help them to re-enter treatment.

Relapse Prevention and Recovery Skills

CSAT believes that the staff of treatment programs should recognize that recovery is a lifelong process and that chronic relapse — viewed by many traditional programs as the fault of the client — be accepted as a “preventable part of the recovery process.” Staff should be prepared to accept women who relapse and to respond appropriately to their needs through training and periodic examinations of the program’s treatment modalities.

As CSAT suggests, certain issues, i.e. self-esteem, sexuality, sexual abuse and violence, cultural roles/identity, communication skills, assertiveness, stress management, family and other relationships, and health are ongoing for women. That is, they need to be addressed both during treatment and during continuing care. Indeed, such issues often “require separate attention and may go beyond the scope of substance abuse treatment.” To prevent relapse, CSAT recommends that women continue to obtain services that address their specific issues after leaving the formal treatment program.

In order to prevent relapse, CSAT recommends that a formal relapse prevention

CSAT Comprehensive Treatment Model

Service Component	Description
Intake Screening/ Comprehensive Health Assessment	Substance abuse history; physical, emotional, and sexual abuse history; educational level and intellectual functioning; work history; family assessment; current living situation and child care responsibilities; relevant racial/cultural/ethnic factors; eligibility for Medicaid, Medicare, SSI, public assistance, and other similar programs. Same-day intake services should be offered when possible. Admission priority should be given to women who are pregnant, HIV-positive, or who have AIDS and/or TB. Comprehensive health assessment may occur over period of time. Should include physical examination, psycho-social examination (including psychiatric assessment where indicated), and assessment of reproductive, oral, and nutritional health status.
Service Planning	Individualized treatment plan including relapse prevention and continuing care. Describes full range of problems that need to be addressed, immediate and long-term goals, and the most appropriate treatment methods and resources to be used. Should be developed in collaboration with woman and reviewed by treatment team with gender-specific and culturally relevant expertise composed of staff members or consultants knowledgeable in substance abuse, physical and mental health professionals, educational and employment specialists, and a child care specialist. Should be revised and updated on ongoing basis, in consultation with the treatment team and the woman herself.
Medical Assessment/Care	Preventive and primary medical care (including prenatal care, if appropriate); medical or medically supervised detoxification services, where clinically indicated; linkage to psychiatric care; provision of or established referral linkages as needed for acute medical care; testing and treatment for hepatitis, tuberculosis, HIV, sexually transmitted diseases, anemia and malnutrition, hypertension, diabetes, cancer, liver disorders, eating disorders, gynecological problems, dental and vision problems, and poor hygiene. Should be provided through arrangements with accessible health care facilities or on-site. It is preferable to have a health care professional available to consult directly with the program.
Women's Health Services	Nutrition, family planning, and general gynecological services. Should be provided through arrangements with accessible health care facilities or on-site. It is preferable to have a health care professional available to consult directly with the program.
Pharmacotherapy Interventions	Antabuse/methadone, as needed. Should include provision of, or established referral linkages for concomitant assessment and monitoring by qualified medical or psychiatric staff.
Urine Testing	Urinalysis conducted on an initial and random basis. Should be used where clinically appropriate.
Infant and Child Health Services	Primary and acute health care for infants and children: immunizations; nutrition services (including assessment for WIC eligibility); developmental assessments. A back-up medical plan containing a protocol for pediatric emergencies should be in place for treatment programs that do not have medical personnel on-site.
Early Intervention Services	Age-appropriate, comprehensive development assessments (including an assessment of learning and developmental disabilities for all children beginning at birth) and services by qualified personnel. Should be provided on-site, or through referral to, early intervention and remedial programs that are linked with Individuals with Disabilities Education Act (IDEA).
Home-Based Support	Public health nursing and/or social work visits provided to high-risk post-partum women and their infants. Linkages for home-based services should be established with home care agencies.

Figure 2

Service Component	Description
Counseling for HIV-Positive/AIDS Patients	Pre- and post-test counseling as well as individual counseling and support groups. Appropriate care for HIV-positive children should also be assured.
Case Management	Activities which bring services, agencies, resources, or people together within a planned framework of action toward the achievement of established goals. May involve liaison activities and collateral contacts. Should be an integral part of the treatment process, from intake through continuing care.
Substance Abuse Education and Counseling, Psychological Counseling, and Other Therapies	Individual/group/family counseling offered in context of families and relationships. Counseling for partners and fathers of babies at critical times throughout treatment. Parenting counseling and education including information on child development, child safety, injury prevention, and child abuse prevention. Should be provided by practitioners who are licensed or certified to provide these services. Should address low self-esteem; race and ethnicity issues; family relationships; attachment to unhealthy interpersonal relationships; interpersonal violence including incest, rape, and other abuse; eating disorders; sexuality; parenting issues; grief related to loss of alcohol and other drugs, children, family, partner, work and appearance; creating a support system that may or may not include family and/or partner; developing a vision of the future and creating a life plan; and therapeutic recreational activities for women alone and with their children. Parenting counseling and education should be integrated with substance abuse counseling in order to be recovery-oriented. Accusatory, judgmental, and humiliation techniques are inappropriate and have not been proven to be effective.
Health Education	HIV/AIDS education; the physiology and transmission of sexually transmitted diseases; reproductive health; understanding female sexuality; preconception care; prenatal care; child birth education; childhood safety and injury protection; physical and sexual abuse education and prevention; nutrition and smoking cessation classes, especially for pregnant women; and general health education.
Life Skills Education	Practical life skills such as parenting where appropriate; vocational evaluation; financial management; negotiating access to services; stress management and coping skills; and personal image-building.
Educational Training	On-site provision of, or case-managed referrals to, local education/GED programs and other remediation issues identified at intake, English language competency and literacy assessment programs, job counseling and training.
Transportation	Transportation to and from treatment and related community services.
Housing	Access to safe, drug-free housing to the maximum extent possible throughout treatment.
Child Care	Age-appropriate care of infants and children provided at treatment facilities using a developmental model. Respite care. If space or licensing requirements prohibit on-site care, contractual arrangements with local, licensed child care providers should be provided.
Continuing Care	Activities that support long-term rehabilitation and prevent relapse. Involves the development of a relapse prevention plan. Should provide for frequent interaction with recovering individuals who have graduated from intensive treatment, and re-admission to more intensive treatment if relapse occurs. Should address continuing effects of domestic violence, rape, and childhood sexual abuse; socio-economic issues such as jobs, education, housing, and transportation issues, as well as primary health care and medical assistance.

component be provided during continuing care to teach women various techniques for “early detection of relapse and mechanisms for intervention.” Such stressors could include, says CSAT, the absence of services provided during the formal treatment program — including housing, health care, employment, child care, and parenting. A relapse prevention component should help women learn how to identify stressors in their lives, as well as how to locate and use resources to cope with them.

Continued family involvement is necessary during the continuing care phase of the program (CSAT, 1994). Involvement of family members is necessary in order to help women recover and become a more functional part of the family system. According to CSAT, “the history and current status of family members—including significant others, children, and parents — are extremely important — if a woman’s significant other has been in recovery but relapses, the program should make an effort to help refer him to treatment and work closely with the woman to help her avoid relapse.”

Access to Services

According to CSAT, housing, health care, employment, child care, and parenting were not considered to be concerns of most substance abuse treatment programs for women in the past; today, however, CSAT considers them to be essential to successful treatment. Housing is considered to be a critical issue for women who are being physically and/or sexually abused, women just released from prison, homeless women, and women who live in an environment supportive of alcohol or other drug use. Because the need for health care will continue after treatment, CSAT suggests that arrangements be made for women and their children to have access to health services before they leave the program.

Economic self-sufficiency, notes CSAT, is important for all recovering women. While job readiness should be an essential part of treatment, illiteracy, inadequate job skills, and child care can prevent women from obtaining employment and should be considered as well. CSAT believes that many women will need assistance developing nurturing relationships with their children and access child care after being discharged from the program. In addition, continued counseling and support or referrals for these services should be provided for women who feel they need assistance developing strong parenting skills.

According to CSAT, several circumstances require special handling during continuing care. The high incidence of HIV/AIDS among substance-abusing women has brought attention to the need for continuing care for addicted women in the terminal stages of any disease. This, says CSAT, involves ensuring that women are provided food, shelter, clothing, access to personal hygiene facilities, compassionate interaction, and assistance addressing unfinished business, and spiritual guidance. For women who have dual disorders, continues CSAT, the period of continuing care following structured treatment can be particularly difficult. Women with dual disorders not only need continuing treatment for the substance abuse problem, but also for the dually-diagnosed disorder as well.

As noted earlier, a significant number of women with substance abuse problems have been adult or childhood victims of emotional, physical, or sexual abuse including incest. Many have been exposed to violence in the communities in which they live or suffered the loss of a family member or friend due to a violent crime. Some women may be vulnerable to continued abuse or violence. CSAT believes it is important that women understand that “relapse can result from difficulties in coping with unresolved issues relating to a history of abuse, or to concerns about current vulnerability to either personal violence resulting from a relationship or exposure to violence.” CSAT stresses the importance of continuing efforts initiated during treatment to help these women address issues related to abuse and violence during this phase of care.

NATURE OF THE SERVICES

Alternative models of substance abuse treatment developed specifically for women place increased emphasis on the idea of alcohol and other drug use as a coping strategy. The characteristics of successful substance abuse treatment programs for women frequently mentioned in the literature are as follows:

- A multidisciplinary team with a single team leader that incorporates the contributions of a variety of disciplines including mental health, social service, medicine, and nutrition;
- Flexible case management that ensures women and children receive needed services by providing an effective communication link among professional providers;
- Inclusion of significant people in the treatment process;
- A nonhierarchical model of open and direct communication and responsibility-sharing that provides a positive model of interdependent relationships for women in treatment; and
- A strong female presence on the staff that in turn communicates acceptance of competent, self-directed women to participants.

According to Schliebner (1994), successful substance abuse treatment programs for women build on nurturance, empowerment, and the importance of relationships. In individual and group therapy, for example, women are encouraged to be active instead of passive, with the woman rather than the therapist seen as the “expert.” Issues that may need to be explored in therapy include: multiple-role strain, unexpressed anger, lack of self-nurturance, parenting, and relationships, violence, depression, and loneliness. A “consciousness-raising” approach should be used that focuses on health rather than illness, respects and values the client’s power, and stresses independence.

Traditionally, men and women have been treated together. George (1990), Travis (1988), and Ford (1987), for example, recommend separate treatment programs for men and women. Nelson-Zlupko et al. (1995) believe that all-female groups provide positive role-modeling, help normalize feelings, develop interpersonal skills, and build support networks. Most importantly, these groups create “a safe and supportive environment” that permits women to discuss issues of sexual, physical, and emotional abuse that they would not share in a mixed group.

Because relationships are very important to women, their treatment should include the significant people in their lives. Schliebner (1994) cites studies noting the importance of the family structure and enlisting their support in the recovery process. The substance-abusing woman often has no sense of her role as an individual beyond that of being a wife and/or mother. The exploration of possible role options and alternatives with family members can encourage women to move in a direction that feels comfortable because it has their support and understanding.

According to VanBremen et al. (1994), programs that are based on traditional models of substance abuse treatment do not integrate parenting and early childhood interventions. Traditional recovery programs, designed by and for men, usually include a full daily routine, strict attention to schedules, and confrontation and punishment for failure to conform. Efforts to participate in all of the services that are provided can consume most of the client’s waking hours. Little time is left for mothers to interact with their children. Many of the staff are recovering persons themselves, who often

continue to use these methods because they believe that this is what helped them to overcome their own addictions.

In recent years, a family-centered model has emerged that takes the concepts of gender-specific treatment a step farther. Family-centered treatment is “comprehensive family habilitation and rehabilitation, with substance abuse treatment as one critical therapeutic component” (Metsch et al., 1995). These programs are designed for the mother and child(ren), instead of a mother with children. Figure 3 shows the service delivery model in such a program.

According to VanBremen et. al (1994), the research supports a mix of parent support and direct developmental services to young children. Programs that emphasize mother-child interaction through modeling, demonstration, and joint activity with the child are more likely to result in stronger parenting effects than time spent talking about

Service Delivery Model Family-Centered Substance Abuse Treatment

(Source: Metsch et al., 1995)

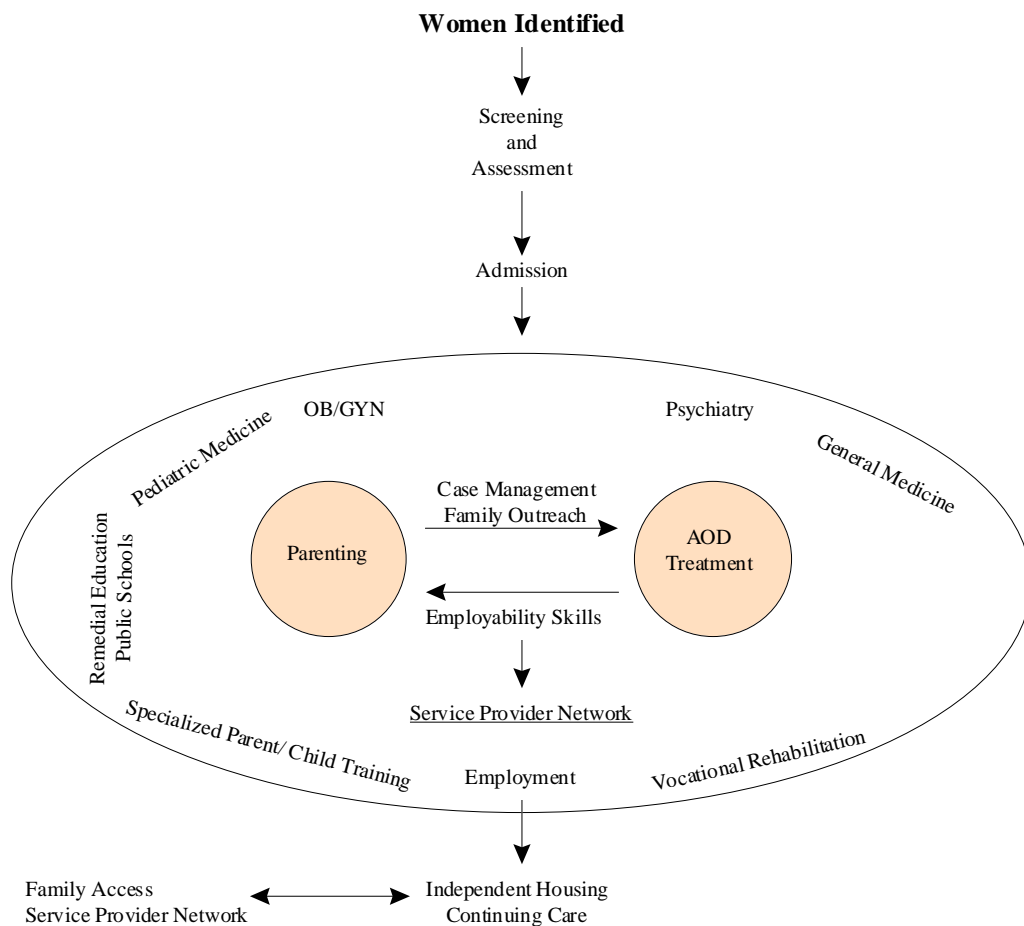


Figure 3

child development. “Effective parenting interventions,” say VanBremen et al., “may include, but are more than, parenting classes with a curriculum to be covered.” The parenting program should, continues VanBremen et al., include:

- Parenting support groups;
- Groups for mothers and infants;
- Individual sessions for mother and infant or child;
- Opportunities for mothers to participate in the child’s day care or classroom;
- Total staff approach geared toward building quality relationships with clients that embody the attributes of successful parenting; and
- Efforts to reach out and encourage the participation of fathers, grandparents, and extended family members.

Most substance treatment agencies believe that achieving sobriety takes precedence over all other objectives. Parenting objectives may not be a high priority, regardless of whether there are children in the program. VanBremen et al. (1994) believe that, if strengthening parenting skills is perceived as aiding in recovery and recovery as resulting in improved parenting, then the two objectives must receive equal weight when program decisions are made. Unfortunately, say VanBremen et al., most addiction counselors believe that abstinence must come first. For this reason, continue VanBremen et al., there will have to be a major shift in beliefs and training before agency staff will be able to provide adequate support to mothers.

BARRIERS TO TREATMENT

According to the authors of *Substance Abuse and the American Woman* (CASA, 1996), women are less likely than men to get treatment for substance abuse. The 1992 National Drug and Alcohol Treatment Utilization Survey found the ratio of men to women in alcoholism treatment to be 3.5 to 1, compared to a ratio of alcohol abuse or dependence of 2.4:1, and the ratio of men to women in drug treatment to be 1.8:1, compared to a drug abuse or dependence prevalence ratio of 2.3:1. There are many barriers that prevent women from seeking treatment, some of which are forced upon women by society (external) and others that are imposed by women themselves (internal).

1. EXTERNAL BARRIERS

Lack of Institutional Mechanisms : Institutional mechanisms that identify men with substance abuse problems are not as available for women. Addicted women, for example, are not as likely as men to be identified in the workplace because proportionately fewer women are employed. Prisons for men are more likely to have medical services, substance abuse treatment, and other support services than those for women. Because women have more contact with staff from social services, Head Start, shelters, hospitals, and emergency departments, the personnel from these organizations should be trained to identify women with substance abuse problems (CSAT, 1993).

Inadequate Training of Health Professionals: Although women see physicians more often than men, physicians are less likely to identify abuse and addiction in women. Women who have substance abuse problems are likely to see a doctor for the medical or psychiatric problems associated with their abuse rather than for the problem itself. Doctors frequently treat the woman's physical or psychological symptoms without dealing with the real problem, often attributing substance abuse symptoms to depression and exacerbating the problem by prescribing psychoactive drugs rather than referring women for treatment (CASA, 1996).

Opposition by Family or Friends: Studies conducted of men and women entering treatment have found that women are more likely than men to lack support or to encounter opposition to treatment from family members and friends (Finkelstein, 1994). Female patients often report that they have delayed seeking treatment because the husbands and children pressed them to stay home and care for the family (CASA, 1996).

Inadequate Financial Resources and Insurance: Women earn less than men, are more likely to be single heads of household, and are much more likely to live in poverty. The cost of treatment may be a significant obstacle to treatment for low-income women who are not likely to have insurance. If a woman does have insurance, it may not cover substance abuse treatment or there may be limits that make it impossible for the woman to obtain treatment. Women who are insured by Medicaid often find it difficult to find programs that will accept this type of payment.

Lack of Child Care: According to CSAT (1993), many women will not enroll in outpatient treatment programs unless they can arrange adequate supervision for their children. A program that does not provide child care, says CSAT, is not truly available to women with children.

2. INTERNAL BARRIERS

Denial of the Problem: Denial is a primary characteristic of addiction. Stigma, shame, and guilt lead to denial of drinking or drug problems by women, many of whom will go to almost any extreme to conceal their substance abuse from outsiders. Outreach programs may be the first step in breaking through denial. A woman who is able to acknowledge that she needs help is much more empowered to accept and remain

Fear of Rejection: Many women live in fear of being rejected or abandoned if loved ones learn that they are addicted to alcohol or other drugs. Fear of rejection may be particularly strong among adolescents, especially those involved in the criminal justice system, whose families may already have rejected them. Women with AIDS and women who are HIV-positive may fear rejection if they have already felt rejected by health care providers, employers, friends, family when they revealed their health status (CSAT, 1993).

Fear of Stigmatization: Many women are afraid to seek treatment because of negative and punitive attitudes attached to being substance-dependent. Alcohol and other drug abuse remain a moral issue for women, and women with substance abuse problems often are viewed as "sexually promiscuous, weak willed, negligent of their children, and irresponsible in their decision to bear more children" (Finkelstein, 1994). Fear of stigmatization intensifies denial, a primary barrier to treatment.

Fear of “Getting Well”: The fear of having to face life without alcohol or other drugs may prevent women with few coping skills from entering treatment. During the outreach phase, these women need to be assured that it is not only possible to face life but to enjoy it without the “help” of mood-altering substances (CSAT, 1993).

Fear of Dealing with Authority Figures: Fear of dealing with authority figures is more common among women from economically or racially disadvantaged populations; women who have previously had negative consequences in trying to obtain social services; women in the criminal justice system who see the system as punitive rather than rehabilitative; female adolescents who have had behavioral problems; illegal aliens who fear deportation; and women who have been victims of incest or sexual abuse (CSAT, 1993).

Fear of Leaving or Losing Children: Many women do not enter treatment programs because they are afraid that they may lose custody of their children. This is particularly true of women already in the criminal justice system who believe that disclosure of a substance abuse problem will be the “last straw” as far as custody is concerned; pregnant women who fear being called “unfit mothers” or face legal sanctions for using drugs while pregnant; women subjected to domestic violence who fear no one will protect their children; homeless women who fear that child protective services will remove their children from their custody; lesbians who are concerned that disclosure will result in losing custody of their children; women with disabilities who, even without the stigma of substance abuse, are perceived as being unable to raise children; and any woman who does not have a support system to care for her children while she is in treatment.

IV. WOMEN IN TREATMENT

The profile of the typical female addict presented by the media is one of a young, poor, black woman with many children who lives on welfare in an urban area and is addicted to crack cocaine. As discussed in the previous section, a review of the literature shows that nationally this often is not the case and that, in fact, the typical chemically dependent woman is most likely to be white, divorced or never married, age 31, a high school graduate, on public assistance, the mother of two or three children, and addicted to alcohol and one other drug.

CHARACTERISTICS

This section contains a description of the demographic, socioeconomic, referral and treatment characteristics of women served by five of the six publicly-funded substance abuse treatment agencies in Hillsborough County during the 1995-96 fiscal year. The description is based on data generated by the State Interim Substance Report (SISAR), a reporting system that tracks substance abuse treatment and prevention populations within the state, and a local substance abuse treatment agency that participates in the system but for whom accurate SISAR data were not available. Differences in the number of women responding to various questions are due largely to which data set was used. Members of the Collaborative have reviewed the profile and agree that, while there may be some variance in the profile of women served by different agencies due to their mission and target population, the overall profile produced by the data is representative of the women that they see in treatment.

Of the women admitted to treatment in Hillsborough County for alcohol and/or other drug problems, the data shows:

- 59.7 percent are 31 to 45 years of age
- 34.9 percent are black, 61.6 percent are white
- 7.3 percent are Hispanic
- 81.9 percent have less than a high school education
- 85.8 percent are not married, widowed, divorced or separated
- 66.4 percent have two or more children
- 67.9 percent are unemployed
- 68.2 percent are living independently
- 84.3 percent have incomes that are less than \$10,400 annually
- 20.9 percent report public assistance to be their primary source of support
- 62.0 percent are without health insurance
- 70.9 percent are involved with the criminal justice system

- 49.1 percent have been admitted to treatment at least one time in the past
- 47.2 percent have a primary addiction to cocaine
- 42.6 percent have a secondary addiction to alcohol
- 40.7 percent exhibit patterns of hard core drug usage
- 7.2 percent are at risk of HIV/AIDS
- 55.7 percent are not likely to complete treatment successfully

1. DEMOGRAPHIC CHARACTERISTICS

Age - Of 670 women responding to a question about their age, 4.2 percent reported that they were 18 to 21, 26.1 percent were 22 to 30, 59.7 percent were 31 to 45, and 10.0 percent were 46 or over.

Race - Of 1,316 women responding to a question about their race, 61.6 percent reported that they were white, 34.9 percent black, and 3.5 percent other.

Ethnicity - Of 1,309 women responding to a question about their ethnicity, 7.3 percent reported that they were Hispanic and 92.7 percent non-Hispanic.

2. SOCIO-ECONOMIC CHARACTERISTICS

Education - Of 1,312 women responding to a question about their educational status, 7.3 percent reported that they did not go to high school, 74.6 percent attended high school but did not go on to college, and 18.1 percent completed high school and attended or graduated college.

Employment - Of 1,292 women responding to a question about their employment status, 7.6 percent reported that they were “not in the labor force.” Of the remaining 1,194 women, 23.7 percent reported that they worked full-time, 8.4 percent worked part-time, and 67.9 percent were unemployed.

Marital Status - Of 1,307 women responding to a question about their marital status, 41.7 percent reported that they were not married, 14.2 percent married, 2.8 percent widowed, 27.3 percent divorced, and 12.9 percent separated.

Dependents - Of 499 women responding to a question about whether they were pregnant when admitted to treatment, 92.9 percent reported that they were not pregnant, 2.8 percent were in their first trimester, 2.6 percent were in their second trimester, and 1.6 percent were in their third trimester. Of 1,104 women responding to a question about whether they had given birth in the last 12 months, 6.0 percent reported that they had a baby one year old or less. Of 640 women responding to a question about dependents 17 years of age or younger, 33.6 percent reported that they had none. The remaining 425 women had between one and seven dependents 17 years of age or younger, for an average of 2.3 dependents per woman.

Living Arrangements - Of 641 women responding to a question about their living arrangements at the time of admission, 1.2 percent reported that they had been homeless, 28.9 percent had been in dependent living situations including halfway houses,

68.2 percent had been in independent living situations, and 1.7 percent had been in institutions including prisons and jails.

Income - Of 670 women responding to a question about their annual income, 84.3 percent reported no income or an income below \$10,400. Of 670 women responding to a question about their annual income, 52.5 percent reported no income, 6.9 percent an income below \$3,000, 9.6 percent an income between \$3,000 and \$5,199, 6.3 percent an income between \$5,200 and \$7,799, 9.1 percent an income \$7,800 and \$10,399, 7.5 percent an income between \$10,400 and \$15,599, and 8.2 percent an income over \$15,600. Of 1,163 women responding to a question about the primary source of their income at the time of admission, 33.6 percent reported that they were supported by wages/salary, 20.9 percent by public assistance, and 18.5 percent by other sources (including illegal income). An additional 27.1 percent of the women reported no source of income.

Health Insurance - Of 600 women responding to a question about health insurance, 62.0 percent reported that they had no insurance, 1.5 percent had Medicare, 24.8 percent had Medicaid, 10.2 percent had private insurance, and 1.5 percent had other insurance.

3. REFERRAL AND TREATMENT CHARACTERISTICS

Outreach - Of 628 women responding to a question about outreach, 29.0 percent reported that formal substance abuse outreach programs/efforts were directly responsible for their decision to seek help.

Source of Referral - Of 1,302 women responding to a question about who had referred them to the program, 46.1 percent reported that they had been referred by the justice system and 4.3 percent by the dependency system. Only 0.2 percent of the women reported that they had been referred by the public health system, and only 0.7 percent reported that they had been referred by the education system. An additional 23.2 percent of the women reported that they had been referred by the social service system (alcohol, drug abuse, mental health, health, and social services agencies). Self-referrals and employer referrals accounted for 25.0 percent and .5 percent of the referrals, respectively.

Prior Admissions - Of 641 women responding to a question about prior admissions, 50.9 percent reported that they had not been admitted for substance abuse treatment prior to this admission. The remaining 315 women had between one and nine prior admissions, with an average of 1.9 prior admissions per woman.

Admission Type - Of 633 women responding to a question about the type of admission, 80.4 percent reported that they had not been admitted to the program previously for treatment, 14.2 percent had been admitted previously to the program for treatment, and 2.8 percent had been transferred to the program for treatment from another program within the agency. An additional 2.5 percent of the women reported that they had been classified as “non-treatment admissions.” That is, they had been admitted to a non-treatment service within the agency such as a Treatment Alternative for Safer Communities, interim, intervention, or prevention service.

Type of Problem (Primary) - According to clinicians, the primary problem of 623 women at the time of admission was cocaine addiction 47.2 percent, marijuana usage

22.2 percent, alcoholism 20.5 percent, and a variety of other alcohol and drug problems 10.1 percent.

Type of Problem (Secondary) - According to clinicians, the secondary problem of 460 women at the time of admission was alcoholism, 42.6 percent; marijuana usage, 31.5 percent; cocaine addiction, 19.1 percent; and other alcohol and drug problems, 6.8 percent.

Extent of Drug Usage - Clinicians reported that 40.7 percent of 593 women had hard core² substance abuse patterns.

Justice System Involvement - Of 634 women, 70.9 percent reported they were involved with the criminal justice system.

Law Enforcement Involvement - Of 643 women responding to a question about how often they had been arrested in the previous 24 months, 31.7 percent reported that they had not been arrested. The remaining 433 women had been arrested between one and nine times, with an average of 1.6 arrests per woman.

Need for Mental Health Services - According to clinicians, 9.7 percent of 646 women were in need or already receiving mental health services, i.e. dually diagnosed with both the need for substance abuse and mental health treatment, at the time of admission.

Risk of HIV/AIDS - Of 646 women responding to questions about intravenous drug use, 13.0 percent reported such usage either currently or in the past. Of 487 women responding to a question about their sexual partners, 2.3 percent reported that they had a sexual partner currently or in the past who was HIV positive. Of 510 women responding to a question about their sexual partners, 6.4 percent reported that they had a sexual partner currently or in the past who used drugs intravenously. Of 516 women responding to a question about their sexual partners, 6.4 percent reported that they had a sexual partner of the same sex currently or in the past.

Discharge Reason - Clinicians responding to a question about the reason for discharge reported that 44.3 percent of 937 women completed treatment. Of the 415 women completing treatment, 94.9 percent were discharged with no substance abuse problem, 2.4 percent were discharged with some substance use, and 2.7 percent were discharged for transfer to another program within the agency. Clinicians responding to a question about the reason for discharge reported that 55.7 percent of 937 women did not complete treatment. Of the 522 women not completing treatment, 59.6 percent left the program early, 18.8 percent were terminated for noncompliance with agency rules, 10.3 percent were transferred to other programs, 9.0 percent did not need further treatment, 1.0 percent were incarcerated, and 1.3 percent were discharged for other reasons.

PERCEPTIONS OF WOMEN IN TREATMENT

The data for this section were obtained from a substance abuse survey that was conducted by the Healthy Start Coalition of Hillsborough County during the fall of 1994

² Using the DSM IV definition.

and the spring of 1995. The data collection instrument used for the survey was adapted from a questionnaire developed for a series of interviews with substance-abusing women that were conducted by the Southern Regional Project on Infant Mortality in 1992. Sites for the Healthy Start survey were selected by a committee established by the Coalition to look at the needs of pregnant and postpartum women with substance abuse problems in Hillsborough County. The committee, which included several substance abuse treatment agencies, chose six sites to survey. Together, the six sites were responsible for the bulk of the county's services to women in the target population.

The committee's goal was to conduct structured interviews with 100 women who either were receiving or had recently completed substance abuse treatment. To volunteer for the survey, women had to be pregnant or with at least one child under the age of two years. In addition, women needed to be or to have been addicted to alcohol or other drugs. Addiction was presumed based on the fact that the women had previously been admitted into treatment. Interviews were completed with 55 women by trained students from the University of South Florida. The women were drawn from a variety of treatment modalities, both public and private. The sample was not meant to be representative of women with addiction as a whole. However, members of the Collaborative agree that it is representative of the pregnant and postpartum women that they see in treatment.

Of the women interviewed by Healthy Start, at least half, 50.9 percent, had to try more than one time to obtain treatment. Nine percent had tried to obtain treatment five or more times. On average, the women had made two attempts to obtain treatment before being admitted to a program. In seeking assistance, the majority of the women first contacted Alcoholics Anonymous, Narcotics Anonymous or Co-dependents Anonymous, 66.7 percent; a counselor/therapist, 62.5 percent; or an attorney, 60.5 percent. The length of time it took women to get into treatment ranged from one month to six years.

Over one-third of the interviewed women, 38.2 percent, indicated they had attempted to enter substance abuse treatment when pregnant. Most of these women, 90.5 percent, told someone at the program to which they were seeking admission that they were pregnant. The majority of the women who revealed that they were pregnant, 80.0 percent, were able to obtain some form of treatment or service. Reasons given by the remaining women for not being able to access treatment included: (1) not being able to find a program that would take pregnant women, 15.0 percent; (2) deciding not to go into treatment, 10.0 percent; and (3) not being able to find a program with an opening, 9.5 percent.

Approximately the same number of women, 39.8 percent, learned that they were pregnant when they were already in treatment. Most of these women, 90.9 percent, told the program operators that they were pregnant. Of the women who revealed that they were pregnant, 80.0 percent experienced no change in their treatment program. Ten percent were referred for prenatal care and medical services. Five percent of the pregnant women were asked to leave the program, while another 5.0 percent were referred to a different program.

Over three-quarters of the women who were interviewed, 78.2 percent, said they had entered treatment because they were concerned about how their drug and/or alcohol use was affecting their children. Almost two-thirds of the interviewed women, 61.8 percent, reported that they had been required to enter treatment by child protective services in order to retain or regain custody of their children. Over half of the women, 56.4 percent, said they had entered treatment because they were "tired of being out on the streets."

Four reasons were mentioned most often for not entering substance abuse treatment by the women who were interviewed:

- They didn't think they had a problem — 68.5 percent;
- They were ashamed about being an alcoholic/drug addict — 61.1 percent;
- They didn't think treatment would help — 53.7 percent; and
- They were afraid their children would be taken away — 50.0 percent.

While a majority of the women cited these reasons for not entering substance abuse treatment, other reasons were important as well. For example, 48.1 percent of the women stated that the reason they did not enter treatment was because they were pregnant and afraid the baby would be taken away. An equal number of the women said they were too depressed by their substance abuse problem to do anything about it.

The women experienced a number of barriers to treatment. The barriers mentioned most frequently were:

Money - Most of the interviewed women were very low income: 47.9 percent had an annual income under \$5,000 and 70.9 percent had an annual income under \$10,000. Despite the availability of some subsidized or free treatment, 44.4 percent of the women reported they had at some time in the past not been able to enter treatment because they did not have the money to pay for it.

Insurance - Many women, 38.9 percent, said that lack of insurance to pay for treatment had prevented them from entering treatment. Only 3.6 percent of the women interviewed by Healthy Start had private insurance. Almost three-quarters, 72.7 percent, were insured by Medicaid, but only 59.3 percent were using Medicaid to pay for their treatment.

Child Care - Although 90.7 percent of the interviewed women had children, only 30.6 percent had children living with them. Almost one-quarter, 22.9 percent, of these children were living in foster homes. Some children, 2.8 percent, were already enrolled in day care when their mothers entered treatment, while others, 4.6 percent, were attending regular school. Most often, the children of women in treatment were cared for by grandparents, 28.4 percent, fathers, 17.4 percent, or other relatives/friends, 19.2 percent, while their mothers were in treatment. Slightly under one-quarter of the interviewed women, 24.1 percent, said the lack of child care had prevented them from entering treatment at some time in the past. However, only 8.5 percent said child care was a problem after entering treatment. On-site child care was provided by the treatment program for 8.3 percent of the children. Over one-third of the women enrolled in programs that did not offer child care, 36.4 percent, believed such services were needed. With respect to child care, it should also be noted that almost one-third of the interviewed women, 31.9 percent, reported their children had health or learning problems. Many of the women had at least one child who had been held back in school, 20.0 percent, diagnosed with a learning disability, 13.3 percent, or placed in a special class for children with learning or physical problems, 13.3 percent.

Transportation - Transportation wasn't a problem for over one-quarter of the interviewed women, 29.1 percent, because they were enrolled in residential treatment programs. However, the remaining women, i.e. those not in residential treatment,

needed to travel up to 42 miles or 90 minutes to get to treatment. Only 28.2 percent of these women owned an automobile. Over half, 51.1 percent, used public transportation to get to treatment. Some were enrolled in programs that provided transportation to treatment, 15.4 percent, or paid for transportation to treatment, 43.6 percent. The reasons cited most often for transportation being a problem for these women were: driver's license taken away; no car; no money for public transportation.

Housing - Many of the interviewed women, 43.1 percent, had been homeless at some point in the last two years. Of these women, 18.2 percent said their homelessness made it difficult for them to enter treatment. A majority of the women who had been homeless, 66.7 percent, believed they were too involved in using drugs and/or alcohol to benefit from treatment during the period they were homeless. A small number of the women, 18.9 percent, lived in public housing, where acknowledging drug addiction can trigger eviction. Of those women who lived in public housing, 38.5 percent said they had been afraid of losing their housing if they entered treatment, but fortunately this had not happened.

A large number of the interviewed women, 75.9 percent, reported having a partner or husband at some time in the past who had similar problems. Over one-quarter of the women, 26.0 percent, said their current partner was a problem drinker or drug user. Many of the women, 39.0 percent, said that the addiction of a partner had made it more difficult for them to enter treatment. A small number, 5.6 percent, had partners at some time who had not want them to go into treatment. Over three-quarters of the women, 78.3 percent, said their current partner was supportive of their decision to enter treatment, while the reactions of 15.7 percent of the partners ranged from being worried to being so angry they had left them. None of the current partners with a drinking or drug problem had entered treatment themselves.

Almost one-third of the women who were interviewed, 29.6 percent, said they had been prevented from seeking treatment because they were in an abusive or violent relationship. Slightly under one-third of the women, 22.2 percent, indicated they had been afraid to enter treatment because they did not want to talk about incidents of sexual abuse in their past.

A majority of the interviewed women said that one or more persons in their lives had tried to get them to stop using alcohol and/or other drugs or to go into treatment. Very few women reported interventions by professionals. Counselors/therapists had tried to get about one-quarter of the women, 22.5 percent, to enter treatment. Only 7.5 percent of the women said a doctor or nurse had tried to get them into treatment, while treatment had been recommended to 10 percent of the women by an attorney.

Most attempts to get the women to stop using alcohol and/or other drugs or to go into treatment were made by a parent, 77.5 percent, partner, 60.0 percent, or other family member, 37.5 percent, who was not necessarily knowledgeable about addiction or treatment services. The most common form of intervention, 91.9 percent, was talking. Less than half of the women were taken to a treatment program, 40.5 percent, or given information about addiction, 40.5 percent. Slightly over half had an appointment made for them with a counselor/program, 51.4 percent, or were given the name/phone number of a program, 56.8 percent.

Most of the interviewed women were influenced to seek treatment because they were concerned about how their use of alcohol/drugs was affecting their lives, 87.3 percent, or about how their alcohol/drug use was affecting their children, 78.2 percent. In addition, many women, 63.6 percent, sought treatment because they had simply "bottomed out" and wanted to change their lives. Well over half of the women, 61.8 percent, were required to obtain treatment by child protective services in

order to keep their children. Some women, 40.0 percent, cited legal problems or arrests as a factor in their decision to enter treatment. Pressure from family, 65.5 percent, friends, 36.4 percent, and partners, 43.6 percent, often was a significant factor for many women. Fear of losing a job or pressure from employers, 14.5 percent, was rarely an important factor for women.

CHANGING PROFILE

There has been a change in the profile of the women seen in treatment for substance abuse over the past five years. In general, the population has become more “hard core.” That is, the women in treatment today have more chronic problems and are much more dysfunctional than those seen in the past. Not only do they have more severe alcohol and other drug problems, but they also are more likely to have serious mental health issues.

Often, the problems experienced by women in treatment are intergenerational. Many women come from families where violence is an all too common solution to problems. Women entering treatment today have less resources available to them and they are less likely to be able to support themselves, both financial and emotionally, than women in the past. These women are less prepared to enter the workforce in terms of their education and vocational skills. Many lack basic living skills. Most women in treatment today do not have extended family locally or even elsewhere that can provide support of any kind.

There are many reasons for the changing profile of women coming into treatment. However, to some extent the changes are due to reductions and shifts in public funding for substance abuse treatment. In recent years, public funds for substance abuse and other related services have been cut drastically and/or shifted to the criminal justice system. At this point in time, few funds are available to pay for treatment unless the individual is involved with the criminal justice system.

Consequently, the woman in treatment today is more likely to have been court-ordered into treatment than in the past. Because the woman is not entering treatment voluntarily, her motivation and stage of readiness are completely different. While this may be the only way to get some of these women into treatment, it tends to slow the recovery process down and increases the likelihood of relapse. As a result, the turnover and recidivism rates for programs are higher today than in previous years.

The changing profile of women in treatment also has had, and will continue to have, an impact on programming. More intense services of longer duration are needed. In addition, if recovering women are going to be able to support themselves and their children, a much more comprehensive approach is needed. It is critical that substance abuse treatment programs address the multiple needs of these women. It is believed that, given the profile of women in treatment today, treatment approaches that are “habilitative” rather than “rehabilitative” in nature need to be developed.

Approximately 4.9 percent of female AFDC recipients are believed to have “significant functional impairment related to substance abuse.” These individuals’ substance abuse problems “may be sufficiently debilitating to preclude immediate participation in employment or training activities.” An additional 10.6 percent of female AFDC recipients are believed to be “somewhat impaired by substance abuse problems, indicating a likely need for substance abuse treatment concurrent with participation in employment and training activities” (U.S. Department of Health and Human Services, 1994). Substance abuse is clearly a barrier to self-sufficiency for many female welfare recipients.

Welfare reform requires AFDC recipients to take part in education and job training programs. Benefits are time-limited and, in the absence of intervention, beneficiaries with substance abuse problems could be ineligible for the program at the end of two years without the ability to be self-supporting. For this reason, intervention with substance-abusing beneficiaries takes on an importance that it has not held previously. In future years, welfare reform can be expected to have a significant impact on the profile of the woman in treatment. The need for more comprehensive, integrated, and habilitative treatment programs should only increase.

TREATMENT PROGRAMS SERVING WOMEN
TREATMENT MODALITY, CAPACITY, AND ENROLLMENT

Program/Provider	Treatment Modality	Daily Capacity	Daily Enrollment	Daily Female Enrollment
Specialized Programs				
Intensive Program/Centre for Women	Outpatient	24	23	23
Explorations Program/Centre for Women	Outpatient	10	9	9
SAMI Program/DACCO	Outpatient/Day-Night	40	34	34
Visions Program/ACTS	Day-Night	12	11	11
Women's Program/Tampa Crossroads	Residential	16	16	16
Non-Specialized Programs				
Adult Detoxification/ACTS	Detoxification	24		
National Center/DACCO	Intervention	30	20	2
TASC/DACCO	Intervention	200	200	51
Bradenton-Phase III/DACCO	Intervention/Outpatient	15	5	1
Chemical Treatment/DACCO	Meth Maint/Outpatient	170	170	79
Outreach-Forensic/Tampa Crossroads	Outpatient	50	35	27
Drug Court/DACCO	Outpatient	140	140	49
DOC Outpatient/DACCO	Outpatient	500	400	94
Outpatient/DACCO	Outpatient	90	81	16
Day-Night Intensive/Goodwill-Suncoast	Outpatient/Day-Night	160	134	25
Residential Treatment/DACCO	Residential	56	52	16
Residential Treatment/ACTS	Residential	16	14	5

Figure 4

V. TREATMENT PROGRAMS

Most substance abuse treatment programs admit women. However, women in general — and pregnant women in particular — are vastly underserved by these programs. While mandating that women, specifically pregnant women, be accepted or given admission priority may be helpful, it does not solve the underlying problem: many treatment programs are not designed with women’s needs in mind and, therefore, are not suitable for women.

Previous sections of this report have shown that women with substance abuse problems need a variety of services. Programs that are designed solely to treat addiction and do not address other needs of women are not truly accessible to women. Without addressing these problems, many women have difficulty entering or continuing treatment, and developing productive, drug-free lives.

This section seeks to answer such questions as: What programs are available in Hillsborough County for women with substance abuse problems? What services do these programs offer? What are the strengths and weaknesses of these programs? How many Hillsborough women are treated by substance abuse programs each year? Is there sufficient capacity for women within the existing system? Could treatment outcomes for women be improved and, if so, how?

This section contains a description of the substance abuse treatment programs serving women in Hillsborough County based on surveys completed by the programs themselves. In this section, specialized programs that only serve women and non-specialized programs that serve both men and women are compared in terms of their general characteristics, service components, and the nature of their services.

To develop this chapter, a survey was conducted of all licensed, publicly-funded substance abuse programs, which serve women in Hillsborough County. The survey was designed by the project consultant and study group based on the results of a literature search summarized earlier in this report. Seventeen programs sponsored by five private not-for-profit agencies responded to the survey. Included in this figure are five specialized programs, which only serve women. Figure 4 displays information about treatment modality, daily capacity, daily enrollment, and daily female enrollment for each program completing a survey.

Analysis of the survey responses show the daily capacity of the publicly-funded substance abuse treatment system in Hillsborough County to be 1,553. Females represent about one-third, 34.0 percent, of the 1,349 clients enrolled in the system on any given day. Of the 459 women in treatment, 93 or 20.2 percent are enrolled in specialized programs for women. Consistent with funding requirements, over half, 55.6 percent, of the 459 women in treatment are criminal justice system placements.

A total of 1,808 unduplicated females enter treatment each year in Hillsborough County. Almost one-quarter, 24.7 percent, of these women enroll in specialized programs, which only serve women. Of the women entering treatment, 1,289 or 71.3 percent are of child-bearing age; 888 or 49.1 percent have minor children; and 98 or 5.4 percent are pregnant. A total of 336, 29.0 percent, of the women of child-bearing age and 309, 34.8 percent, of the women with minor children enroll in specialized programs while 70, 71.4 percent, of the pregnant women enter such programs.

GENERAL SURVEY FINDINGS

1. The substance abuse treatment system in Hillsborough County operates at capacity; that is, at least 87 percent of the slots in the system are filled on any given day.

2. Based on national figures, less women receive treatment in Hillsborough County than would be expected.
3. Approximately half of the Hillsborough women in treatment have been treated at least one time previously.
4. The only treatment slots in Hillsborough County set aside specifically for women are those in specialized “women only” programs.
5. Over one-quarter of the Hillsborough women who receive treatment are enrolled in specialized programs, which only serve women.
6. Access to treatment for women not referred by the criminal justice system is limited; only 86 (16 percent) of 546 slots available for men and women not referred by the criminal justice system are designated for female clients.
7. Admission priorities are established by funding sources; women who do not fall into a priority population are not likely to be served.
8. Only one-quarter of the adult detoxification slots are filled by women on any given day. Pregnant women are not admitted into adult detoxification without medical clearance.
9. There are no residential treatment programs in Hillsborough County that accommodate mothers wishing to keep minor children with them while undergoing treatment.
10. There are no residential treatment programs in Hillsborough County designed specifically for women who are not referred by the criminal justice system.
11. Day-night and intensive outpatient treatment programs are used in Hillsborough County as a substitute to residential treatment for women who are not referred by the criminal justice system.
12. At least one of the county’s intensive outpatient treatment programs uses “recovery houses” as a cost-effective substitute to residential treatment for female clients with minor children who are in need of “safe” housing.
13. The length of care in specialized programs, which only serve women, tends to be shorter (three to six months) than in non-specialized programs which serve both men and women (six months to over one year). Specialized programs are less likely to perceive the length of care in their programs as being “just right” and more likely to see the length of care as being “too short.”

SERVICE COMPONENTS

1. While specialized programs are more likely than non-specialized programs to engage in community outreach or case finding activities, neither specialized nor non-specialized programs have extensive outreach programs.
2. While specialized and non-specialized programs collect similar intake data from female clients, specialized programs tend to collect more information about women’s health issues.
3. Most medical data collected at intake is self-reported.
4. Female clients in specialized programs are more likely than their counterparts in non-specialized programs to be screened for the following problems:
 - Reproductive
 - Psychiatric
 - Physical Health
 - TB
 - HIV/AIDS
 - Developmental Disabilities
5. Female clients in specialized programs and their counterparts in non-specialized programs are equally likely to be screened for the following problems:
 - Psychosocial
 - Cognitive impairments
 - Co-occurring mental illness

6. Female clients in specialized programs are less likely than their counterparts in non-specialized programs to be screened for the following problems:
 - Biopsychosocial stressors
7. Screening of female clients for health problems is usually accomplished through referral.
8. Standardized instruments are rarely used to screen female clients in either specialized or non-specialized programs.
9. Female clients in specialized programs are more likely than female clients in non-specialized programs to receive primary and prenatal care.
10. Female clients in specialized and non-specialized programs are equally likely to receive postpartum care.
11. In general, medical care in both specialized and non-specialized programs is provided by referral. Follow-through on referrals is usually not documented by either type of program.
12. Female clients with dual diagnoses are more likely to receive services in specialized programs than in non-specialized programs, especially if they are stabilized on medication.
13. Individual treatment plans are required of all licensed substance abuse treatment programs by the Department of Children and Families. The Department of Corrections does not require individual treatment plans for its outpatient programs. The Department of Children and Families waives the individual treatment plan requirement for outpatient programs fund by the Department of Corrections.
14. Multi-disciplinary review of individual treatment plans for female clients, individually or as a team, is equally unlikely in specialized and non-specialized programs.
15. While similar types of assistance are offered through case management to female clients in both specialized and non-specialized programs, the former tend to focus more on gender-specific needs, i.e. assistance obtaining transportation and child care.
16. Few specialized or non-specialized programs employ pharmacotherapeutic interventions. Some programs are philosophically opposed to their use, while other programs simply do not have qualified medical or psychiatric staff available to monitor these interventions.
17. All specialized and non-specialized programs ask female clients to submit to urine tests.
18. With respect to types of substance abuse counseling services, female clients in specialized programs are more likely than female clients in non-specialized programs to be able to access individual, group, and family counseling.
19. Female clients in specialized programs are more likely than female clients in non-specialized programs to be able to access substance abuse counseling services that address gender-specific issues, such as loneliness, depression, domestic violence, sexual abuse, relationships, parenting, lack of self-nurturance, unexpressed anger, and multiple role strain.
20. Race and ethnicity, eating disorders, sexuality, and therapeutic recreational activities for women alone and with their children are only addressed “a little” by the substance abuse counseling and education components of both specialized and non-specialized programs.
21. Female clients in specialized programs are more likely than female clients in non-specialized programs to receive health education and life skills education.

22. Reproductive health, female sexuality, family planning, preconception care, child birth education, childhood safety, smoking cessation, and nutrition are only addressed “a little” by the health education components of both types of programs.
23. Female clients in all specialized programs are able to access parenting education, while female clients in few non-specialized programs are able to access parenting education.
24. The minor children of female clients in specialized programs are more likely to be referred for needed services (i.e. physical examinations, primary health care, immunizations, treatment for perinatal effects of maternal substance abuse, screening regarding mental development, HIV/AIDS services, counseling for physical and sexual abuse, other mental health and social services, and home visitation) than are the children of female clients in non-specialized programs.
25. The minor children of female clients in specialized and non-specialized programs are equally unlikely to be linked with IDEA for services.
26. Female clients in specialized programs and female clients in non-specialized programs are equally likely to receive assistance finding housing.
27. Female clients in specialized programs are more likely to receive child care while in treatment, transportation, and continuing care than are female clients in non-specialized programs.
28. While specialized programs are more likely than non-specialized programs to offer parenting support groups and individual sessions for mother and child, neither type of program engages extensively in either of these activities and neither offers special groups for mother and infant or opportunities for mothers to participate in the child’s day care program.
29. Female clients in specialized programs are more likely than female clients in non-specialized programs to receive continuing care and to receive it for a longer period of time.
30. Female clients in specialized programs are more likely than female clients in non-specialized programs to receive individual, family, and collateral counseling as well as relapse prevention during continuing care.
31. Female clients in specialized programs are more likely than female clients in non-specialized programs to receive assistance accessing community services; coordinating appointments with service providers; and obtaining health care services, housing, child care, transportation, employment, continuing education, and social services.
32. Specialized and non-specialized programs have different perceptions of the service components that most need to be strengthened. These differences appear to be related to the services that each currently provide.

Specialized Programs

Medical assessment and care
 Women’s health
 Educational training
 Early intervention
 for infants/children
 Home-Based Support
 Housing
 Pharmacotherapy interventions

Non-Specialized Programs

Housing
 Transportation
 Child care
 Infant/child health services
 Early intervention
 for infant/children
 Home-based support

NATURE OF SERVICES

1. Specialized and non-specialized programs are equally likely to take an “eclectic” approach to treatment; no gender-specific programs, however, are based on the medical model.
2. Female clients in specialized programs are more likely than female clients in non-specialized programs to be able to access substance abuse counseling services presented in the context of families and relationships.
3. The partners, parents, children, other family members, and friends of female clients in specialized programs are more likely to be able to access substance abuse counseling services than are those of female clients in non-specialized programs.
4. Female clients in all specialized programs are able to access gender-specific, i.e. “women’s only,” groups, while female clients in few non-specialized programs are able to access such groups.
5. Specialized programs are more likely than non-specialized programs to support the following statements:
 - The idea of alcohol and other drug use as a coping strategy is stressed.
 - The program focuses on the positive aspects of health.
 - The program’s female clients would benefit from a multidisciplinary staffing.
 - Role options/alternatives for female clients are explored with family members.
 - Parenting and early childhood interventions are integrated with the treatment regimen.
 - Mother-child interaction is emphasized through modeling, demonstration, and joint activity with the child.
 - The program emphasizes the importance of developing the attributes of successful parenting.
 - The program makes efforts to reach out and encourage the participation of fathers, grandparents, and extended family members of female clients in the program.
6. Specialized programs are less likely than non-specialized programs to support the following statements:
 - The disease concept of addiction is emphasized.
 - The program’s counselors encourage female clients to be active rather than passive.
 - Female clients are encouraged to see the therapist as the expert.
 - Achieving sobriety takes precedence over all other objectives.
7. Specialized and non-specialized programs are equally likely to support the following statement:
 - The program respects and values the female client’s power, and stresses independence.

VI. CONCLUSIONS, RECOMMENDATIONS, ISSUES

CONCLUSIONS

When the Women’s Substance Abuse Collaborative first proposed this analysis to the Human Service Work Group, the questioning was quite intense. The Work Group wanted to know if there really were differences in the patterns, characteristics, consequences, and origins of substance abuse between women and men. Its members were curious about what motivated women to seek — or not to seek — treatment and if it was likely to be different from what motivated men. They wondered if and why it was important for treatment programs to examine substance abuse by women as a separate and distinct issue, and what specific services are needed by women.

Women and Substance Abuse in Hillsborough County, Florida answers these questions. The report shows that women and men differ significantly in their risk factors, physiology, psychology, and patterns of abuse and addiction, and that what motivates women to seek treatment is likely to be different from what motivates men. The reasons women abuse alcohol and other drugs are discussed as well as the implications for treatment. Barriers that prevent women from obtaining substance abuse treatment are identified. The report describes both the type and nature of substance abuse services needed by women.

The report began with a description of the patterns, characteristics, and consequences of alcohol and other drug usage by women in the United States as revealed by a review of the literature. The information in this section led the study group to conclude:

1. Substance abuse among women is widespread, with approximately one in five women in the United States now abusing or becoming dependent on alcohol and/or other drugs at some point in their lives;
2. While it is true that more men than women abuse alcohol and other drugs, the “gender gap” has closed significantly in recent years;
3. Psychological pressures, traumatic events, and family demands contribute more to the use and abuse of alcohol and other drugs by women and need to be considered in their treatment;
4. Women feel the physical effects of alcohol, become addicted, and develop alcohol-related illnesses more rapidly than men, i.e. “get sicker quicker;” and
5. Women of child-bearing age who abuse alcohol and/or other drugs expose their children to health and developmental problems as well as child abuse and neglect.

The second section of *Women and Substance Abuse in Hillsborough County, Florida* discussed the addictive process and various treatment approaches based on the literature. In addition, this section described alternative programs designed specifically for women and the “ideal” substance abuse program/service continuum for women, also as suggested by the literature. Based on the information in this section, the study group concluded:

1. A woman's substance abuse should be addressed in the context of her health and her relationship with her children and other family members, the community, and society;
2. Most substance abuse treatment programs are designed for males and do not take into account physiological, psychological, treatment, and risk factor differences between males and females;
3. Treatment programs should offer women a continuum of services from outreach through continuing care;
4. For substance-abusing women, the setting, i.e. outpatient, day treatment, residential, and length of care, i.e. short-term, long-term, should be based on their treatment needs;
5. Substance abuse treatment for women should be family-centered, i.e. address the mother and child as well as the woman's partner and family; comprehensive, i.e. provide all the services needed by women and their children; and coordinated, i.e. draw together multiple services, with direct collaboration among providers; and
6. The following services should be provided for substance-abusing women as listed in a continuum-of-care:

a. Detoxification	b. Intake screening
c. Comprehensive assessment	d. Service planning
e. Case management	f. Medical assessment/care
g. Women's health services	h. HIV testing/counseling
i. Pharmacotherapy	j. Urine testing
k. Substance abuse education	l. Substance abuse counseling
m. Psychological counseling	n. Other therapies
o. Infant/child health services	p. Early intervention services
q. Home-based support	r. Life skills education
s. Health education	t. Transportation
u. Housing assistance	v. Child care
w. Academic education	x. Vocational/job skills training
y. Employment preparation/job placement	z. Continuing care
7. For substance abuse treatment to be effective for women, it should be offered in gender-specific programs that are ethnically and culturally sensitive;
8. In order to ensure that women and children receive needed services, case management should be provided by a multidisciplinary team with a single team leader; and
9. For substance abuse treatment programs to be successful for women, they should nurture, empower, and emphasize the importance of relationships.

The next section of the report profiled chemically dependent women in Hillsborough County. Women who were treated for substance abuse during the 1995-96 fiscal year were described as were the experiences of a group of pregnant/postpartum women who received treatment during the 1994-95 fiscal year. Also presented in this section were the views of service providers with respect to the changing profile of women in treatment. The study group concluded:

1. Women undergoing substance abuse treatment in Hillsborough County often are seriously addicted and have been in treatment before;

2. The majority of women who enter substance abuse treatment programs in Hillsborough County:
 - are unemployed,
 - are poor,
 - have two or more children,
 - are not married,
 - are living independently,
 - have no high school diploma, and/or
 - lack employability skills;
3. A large number of TANF recipients in Hillsborough have substance abuse problems that interfere with their ability to maintain employment;
4. There has been a change in the profile of Hillsborough women in treatment over the past five years, with the population becoming more “hard core;”
5. Women do not enter substance abuse treatment earlier in Hillsborough County because:
 - They don’t think that they have a problem,
 - they are ashamed about being an alcoholic/drug addict,
 - they don’t think treatment will help, and
 - they are afraid their children will be taken away;
6. Many women who enter in Hillsborough treatment programs have children with health or learning problems;
7. Substance abuse is believed to be a major factor contributing to removal in the majority of the child welfare cases involving Hillsborough County children;
8. Barriers to treatment cited most often by Hillsborough women in treatment are:
 - money,
 - lack of insurance,
 - lack of child care, and
 - lack of transportation;
9. Women enter treatment in Hillsborough County because:
 - They are concerned about how their addiction is affecting their lives,
 - they are concerned about how their addiction is affecting their children,
 - they are pressured to obtain treatment by their families,
 - they “bottom out” and want to change their lives, and
 - they are ordered or placed into treatment by the courts or criminal justice system.

Women and Substance Abuse in Hillsborough County, Florida continued with the results of a survey that was conducted of all licensed, publicly-funded substance abuse treatment programs that serve women in Hillsborough County. Descriptions of the programs were provided based on surveys completed by the programs themselves. In the section, specialized programs for women were compared with non-specialized programs which serve both men and women. The conclusions of the study group were as follows:

1. Women with substance abuse problems are underserved in Hillsborough County;
2. Substance abuse programs, which serve women, both specialized and non-specialized, are operating at capacity in Hillsborough County;
3. The opportunity to obtain specialized gender-specific treatment and services for women is limited in Hillsborough County;
4. Programs offering specialized gender-specific treatment for Hillsborough women provide more family-centered, comprehensive, and coordinated services for women;

5. Specialized programs, which offer gender-specific treatment for women, are more likely to emphasize nurturance, empowerment, and the importance of relationships;
6. The children of substance abusing mothers in Hillsborough County are better served by specialized programs, which provide gender-specific treatment;
7. Lack of money, insurance, child care, and transportation are barriers to Hillsborough women entering treatment;
8. Access to treatment for women is adversely affected by inadequate outreach in Hillsborough County;
9. Pregnant women who cannot obtain medical clearance are unable to access detoxification services;
10. Communication links among professional providers involved with women in treatment and their children need to be improved in Hillsborough County;
11. Day-night and intensive outpatient programs with extensive ancillary services (including “recovery homes”) are used in Hillsborough County as a less expensive substitute to residential treatment for women with minor children who remain with them while undergoing treatment
12. The services most in need of strengthening in specialized programs for women are: medical assessment and care, women’s health services, educational training, early intervention for infants and children, home-based support, and housing assistance; and
13. The services most in need of strengthening in non-specialized programs that serve both men and women are: housing assistance, transportation, child care, infant/child health services, early intervention for infants and children, home-based support, and pharmacotherapy interventions.

RECOMMENDATIONS

The study group has developed a number of recommendations based on the information and conclusions presented in this report. The recommendations should be of interest to providers, planners, and funders of all services that impact the family, and are as follows:

1. **Finding: Traditional substance abuse programs are male-oriented; women require gender-specific treatment.**

Discussion

✓ A woman’s substance abuse must be addressed in the context of her health and her relationship with her children and other family members, the community, and society. Substance abuse treatment for women should be family-centered, comprehensive, and coordinated. Successful substance abuse treatment programs for women nurture, empower, and emphasize the importance of relationships.

✓ In Hillsborough County, specialized programs for women that offer gender-specific treatment and ancillary services, are more family-centered, offer more comprehensive, and coordinated services, and are more likely to emphasize nurturance, empowerment, and the importance of relationships. In addition, the children of substance abusing mothers in Hillsborough County are better served by these specialized treatment programs.

✓ Substance abuse treatment is more effective for women when provided by specialized programs which are designed specifically for females and offer gender-specific treatment. Most Hillsborough women are treated in programs that serve both men and women, are designed primarily for males, and generally do not take into account differences between males and females. Although these programs may be effective for some women, their effectiveness could be improved if they included gender-specific treatment.

Recommendation 1 — Nature of Program

A. Continue, modify, and establish substance abuse programs for women that offer gender-specific treatment, which nurtures, empowers, and emphasizes the importance of relationships, and provides family-centered, comprehensive, and coordinated services.

2. **Finding: In Hillsborough County, the substance abuse treatment capacity for women — particularly in specialized programs which offer gender-specific treatment and ancillary service — is insufficient.**

Discussion

✓ Women with substance abuse problems are underserved in Hillsborough County. Substance abuse programs, which serve both men and women, are operating at capacity. Specialized programs for women, which offer gender-specific treatment and ancillary services, are likely to have waiting lists.

Recommendation 2 — Treatment Capacity

A. Expand the capacity of substance abuse programs that serve women, particularly specialized programs that offer gender-specific treatment and ancillary services.

3. **Finding: Access to treatment for women is adversely affected in Hillsborough County by inadequate outreach to women.**

Discussion

✓ Internal barriers often prevent women from entering treatment. In Hillsborough County, the internal barriers to treatment cited most often by women are: denial of the problem, shame and fear of rejection, belief that treatment will not help, and fear of losing children.

✓ External barriers can prevent women from entering treatment as well. The external barriers to treatment mentioned most often by Hillsborough women are: insufficient financial resources, no insurance, inadequate child care, transportation, and lack of housing.

✓ Because the treatment system operates at capacity in Hillsborough County, there are no ongoing, organized efforts to reach out to women in need of substance abuse treatment and to help them overcome barriers to treatment.

Recommendation 3 — Access to Services

A. As the treatment capacity for women is increased, strive to overcome barriers to access by developing specialized outreach services designed to help women overcome barriers to treatment.

B. Specialized outreach services should present a balanced message that does not blame women for their addiction problems, but instead recognizes the need for personal responsibility, communicates an understanding of the stress that women face in their daily lives, and acknowledges cultural or gender roles that contribute to or help reduce such stress.

C. Specialized outreach efforts should target the addicted woman and her support group (family, significant others, friends, co-workers). In addition, special efforts should be made to inform community groups, government agencies, public health and social service organizations, the law enforcement and criminal justice system, charities and places of worship about substance abuse programs and services that are available for women. Special efforts also should be made to reach out to child welfare workers so that substance-abusing women with children at risk of or already in out-of-home care are able to obtain treatment.

4. Finding: In addition to “core” substance abuse services, programs that serve women should include access to certain ancillary services.

Discussion

✓ While the setting, length of care, and specific services provided to women should be determined based on individual need, all women in treatment for substance abuse should have access to certain core and ancillary services, both of which are designed specifically for females and compatible with generally accepted standards for gender-specific treatment.

✓ In Hillsborough County, the ancillary services most in need of strengthening in specialized substance abuse treatment programs for women are: medical assessment and care, women’s health services, educational training, early intervention for infants and children, home-based support, and housing assistance.

✓ The ancillary services most in need of strengthening in Hillsborough substance abuse treatment programs, which serve both men and women, are: housing assistance, transportation, child care, infant/child health services, early intervention for infants and children, home-based support; pharmacotherapy interventions.

Recommendation 4 — Types of Services Needed

A. All women in treatment for substance abuse should have access to the following core and ancillary services in the continuum-of-care as listed:

- | | |
|---|-----------------------------------|
| a. Detoxification | b. Intake screening |
| c. Comprehensive assessment | d. Service planning |
| e. Case management | f. Medical assessment/care |
| g. Women’s health services | h. HIV testing/counseling |
| i. Pharmacotherapy | j. Urine testing |
| k. Substance abuse education | l. Substance abuse counseling |
| m. Psychological counseling | n. Other therapies |
| o. Infant/child health services | p. Early intervention services |
| q. Home-based support | r. Life skills education |
| s. Health education | t. Transportation |
| u. Housing assistance | v. Child care |
| w. Academic education | x. Vocational/job skills training |
| y. Employment preparation/job placement | z. Continuing care |

5. Finding: Effective substance abuse treatment for women requires collaboration among Hillsborough County planners, funders, and providers.

Discussion

✓ The program model recommended in this report includes ancillary services not traditionally viewed as “substance abuse treatment,” but which are believed to be essential to recovery for women. Currently, most women treated for substance abuse in Hillsborough County do not receive these services.

✓ Modifying existing substance abuse treatment programs for women to include nontraditional ancillary services is counter to the current trend in the field. In fact, the range of services offered by substance abuse treatment programs is expected to narrow in the immediate future as more of these programs fall within the purview of managed care.

✓ Under managed care, planners, funders, and providers of substance abuse treatment programs, which serve women, will need to work more closely with planners, funders, and providers of the ancillary services needed by women during and after treatment. Service networks, communication linkages, and coordination between providers of substance abuse treatment and ancillary services need to be strengthened. Planners and funders can assist providers by eliminating barriers to improved collaboration.

Recommendation 5 — Collaboration

A. Planners and funders of substance abuse treatment and ancillary services needed by women during and after treatment should address the need for improved service networking, communication links, and coordination by facilitating changes that make it easier for providers to work together.

B. The providers of substance abuse treatment for women should: (1) develop a mechanism to facilitate networking in the provider community; (2) maintain linkages with the providers of ancillary services needed by women during and after treatment; and (3) maintain linkages with planners and funders of substance abuse treatment and ancillary services to communicate the need for these services.

6. Finding: Women who abuse alcohol and/or other drugs, particularly those of child-bearing age, expose their babies and children to serious health and developmental problems as well as abuse and neglect.

Discussion

✓ The majority of the women who enter substance abuse treatment programs in Hillsborough County have children. Many of these children have physical, mental and developmental problems. In addition, a large number of the children have been abused and/or neglected by their mothers, and have been and/or are at risk of being removed from the home.

✓ Substance abuse treatment programs, which serve women, should (1) promote health and wellness, and emphasize responsible adult roles; (2) support the stability and functioning of families, including family reunification, prevention of child abuse/neglect, and economic self-sufficiency; and (3) improve the resiliency of children and youth so they are able to maintain a healthy drug-free lifestyle and to perform well in school.

✓ Substance abuse treatment programs, which serve women, should provide, either directly or indirectly: (1) parenting services that promote effective parent/child interaction, personal growth and development, and increase family support; (2) child development services that promote the physical, social, emotional, and cognitive development of young children; and (3) substance abuse intervention services that decrease the relapse rate among women and prevent substance abuse by their children.

✓ Effective treatment of women with substance abuse problems and their children requires multiple services that cross human service delivery systems. The cross-system nature of their needs necessitates the establishment of a mechanism to ensure that human service planners and funders are able to address this issue as a high priority within and across all systems. Improved coordination among planners and funders of substance abuse treatment and other related services should increase the likelihood of developing a “seamless service system” for families affected by substance, thus making more cost-effective use of the limited funds that are available to respond to this issue.

Recommendation 6 — Service Planning and Funding

A. Local planners and funders of human services should develop a community strategy to prioritize existing and anticipated needs for substance abuse treatment and ancillary services for women across all service delivery systems.

B. The community strategy should support the funding of substance abuse treatment and ancillary programs and services for women that:

- Promote health, wellness and responsible adult roles for women;
- Support the stability and functioning of families;
- Build the resiliency of children and youth so they are able to maintain a healthy drug-free lifestyle and perform well in school; and
- Provide, either directly or indirectly, services that enhance parenting skills, facilitate child development, and deter relapse and prevent substance abuse by their children.

C. Having established a community strategy, local funders and planners of human services should encourage use of the strategy for funding substance abuse treatment and ancillary programs and services needed by Hillsborough women during and after treatment.

OUTSTANDING ISSUES

In developing *Women and Substance Abuse in Hillsborough County, Florida*, the study group decided to use the report to educate readers about problems of addiction as they relate to women. For this reason, this report contains much information that otherwise might not have been included. However, in order to keep the report focused, a number of important issues identified during the study were not explored. Each issue alone is believed by the study group to be worthy of analysis. The issues are as follows:

Programmatic Issues

1. Services for special populations
 - Dually diagnosed
 - Terminally ill
 - Victims of violence
2. Medical services
3. Counseling services
 - Ethnic and cultural sensitivity
 - Eating disorders
 - Sexuality
 - Therapeutic recreational activities
4. Health education services
 - Reproductive health
 - Female sexuality
 - Family planning
 - Preconception care
 - Child birth education
 - Childhood safety
 - Smoking cessation
 - Nutrition

5. Life skills education

- Parenting support groups
- Individual sessions for mother and child
- Special groups for mother and infant
- Opportunities for mothers to participate in the child's day care program

Infrastructure Issues

1. Standardized assessment instruments for all programs
2. Uniform treatment plans for all programs
3. Outcome measures for all programs
4. Reliability of program data in all programs
5. Integrated (shared) management information system between all programs
6. Impact of managed care on all programs

FINAL COMMENTS

At the outset of this project, members of the Women's Substance Abuse Collaborative believed that the analysis would improve collaboration and strengthen coalitions among the providers, planners, and funders of substance abuse services, and produce recommendations that, when implemented, would lead to system redesign and ultimately to substance abuse services that have the capacity to more comprehensively and successfully intervene with substance-abusing families.

While this is but the first step in redesigning the existing system of substance abuse treatment services for women so that they are more comprehensive and family-centered, the Collaborative believes the project has improved collaboration and strengthened coalitions among providers, planners, and funders of substance abuse services. Members of the Collaborative look forward to partnering in the future to better meet the needs of Hillsborough County families.

REFERENCES

- Abbott, A. A. (1994). A feminist approach to substance abuse treatment and service delivery. *Social Work in Health Care*. 19(3/4): 67-83.
- Besharov, D. (1990). Testimony before U.S. Senate, Subcommittee on Children, Families, Drugs and Alcoholism, Feb 5. In Office of Substance Abuse Prevention (1992). *Identifying the needs of drug-affected children: Public policy issues*. Rockville, MD: U.S. Department of Health and Human Services, Public Health Service.
- Center on Addiction and Substance Abuse (1996). *Substance Abuse and the American Woman*. New York, NY: Columbia University.
- Center for Substance Abuse Prevention (1993). *Pregnancy and exposure to alcohol and other drug use*. Rockville, MD: U.S. Department of Health and Human Services, Public Health Service.
- Center for Substance Abuse Treatment (1994). *Practical approaches in the treatment of women who abuse alcohol and other drugs*. Rockville, MD: U.S. Department of Health and Human Services, Public Health Service.
- Covington, S. (1991) Presentation at a conference on women and addictions, Santa Clara City Health Department, San Jose, CA. In Center for Substance Abuse Treatment (1994). *Practical approaches in the treatment of women who abuse alcohol and other drugs*. Rockville, MD: U.S. Department of Health and Human Services, Public Health Service.
- Daro, D. and Mitchell, L. (1990). *Current trends in child abuse reporting and fatalities: The results of the 1989 survey*. Chicago: National Committee for the Prevention of Child Abuse. In Office of Substance Abuse Prevention (1992). *Identifying the needs of drug-affected children: Public policy issues*. Rockville, MD: U.S. Department of Health and Human Services, Public Health Service.
- Finkelstein, N. (1994). Treatment issues for alcohol- and drug-dependent pregnant and parenting women. *Health & Social Work* 19(1): 7-15.
- Ford, B. (1987). *A glad awakening*. New York: Doubleday. In Schliebner, C.T. (1994). Gender-sensitive therapy: An alternative for women in substance abuse treatment. *Journal of Substance Abuse Treatment* 2(6): 511-515.
- George, R.L. (1990). *Counseling the chemically dependent: Theory and practice*. Boston, MA: Allyn and Bacon. In Schliebner, C.T. (1994). Gender-sensitive therapy: An alternative for women in substance abuse treatment. *Journal of Substance Abuse Treatment* 2(6): 511-515.
- Goldberg, M.E. (1995). Substance-abusing women: False stereotypes and real needs. *Social Work* 40(6): 780-798.
- Hilton, M.E. and Clark, W.B. (1987). Changes in American drinking patterns and problems, 1967-84. *Journal of Studies on Alcohol* 48(6): 515-522. In Abbott, A. A. (1994). A feminist approach to substance abuse treatment and service delivery. *Social Work in Health Care*. 19(3/4): 67-83.
- Kauffman, E., Dore, M.M., and Nelson-Zlupko. (1995). The role of women's therapy groups in the treatment of chemical dependence. *American Journal of Orthopsychiatry* 65(3): 355-363.
- Mangano, M.F. (1990). Testimony before U.S. Senate, Subcommittee on Children, Families, Drugs and Alcoholism, Mar 8. In Office of Substance Abuse Prevention (1992). *Identifying the needs of drug-affected children: Public policy issues*. Rockville, MD: U.S. Department of Health and Human Services, Public Health Service.
- Metsch, L.R., Rivers, J.E., Miller, M., Bohs, R., McCpy, C.B., Morrow, C.J., Bandstra, E.S., Jackson, V.J., and Gissen, M. (1995). Implementation of a family-centered treatment program for substance-abusing women and their children: Barriers and resolution. *Journal of Psychoactive Drugs* 27(1): 73-83.

Nelson-Zlupko, L., Kauffman, E., and Dore, M.M. (1995). Gender differences in drug addiction and treatment: Implications for social work intervention with substance-abusing women. *Social Work* 40(1): 45-54.

Office of Substance Abuse Prevention (1992). *Identifying the needs of drug-affected children: Public policy issues*. Rockville, MD: U.S. Department of Health and Human Services, Public Health Service.

Schliebner, C.T. (1994). Gender-sensitive therapy: An alternative for women in substance abuse treatment. *Journal of Substance Abuse Treatment* 2(6): 511-515.

Travis, C.B. (1988). *Women and health psychology*. Hillsdale, NJ: Erlbaum. In Schliebner, C.T. (1994). Gender-sensitive therapy: An alternative for women in substance abuse treatment. *Journal of Substance Abuse Treatment* 2(6): 511-515.

U.S. Department of Health and Human Resources, Office of the Assistant Secretary for Planning and Evaluation, the Public Health Services, the National Institutes of Health/National Institute on Drug Abuse, and the Substance Abuse and Mental Health Services Administration (1994). *Patterns of Substance Use and Substance Related Impairment Among Participants in the Aid to Families With Dependent Children Program (AFDC)*.

VanBremen, J.R. and Chasnoff, I.J. (1994). Policy issues for integrating parenting interventions and addiction treatment for women. *Topics in Early Childhood Special Education* 14(2): 254-274.

Weisner, C. and Schmidt, L. (1992). Gender disparities in treatment for alcohol problems. *Journal of the American Medical Association* 268(14): 1872-1876. In Abbott, A. A. (1994). A feminist approach to substance abuse treatment and service delivery. *Social Work in Health Care*. 19(3/4): 67-83.2



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