Service Providers and Treatment Access Issues

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INTRODUCTION

Traditionally, drug treatment programs have focused on white male addicts and the resources needed to help them in their recovery (Vannicelli 1984). Early efforts to identify the treatment needs of women concentrated on studying white heroin-addicted women (Colten et al. 1979). Only in recent years has increasing attention been given to the treatment of women of childbearing age and the resources they need to recover from addiction.

It is now generally accepted that there are differences between men and women in the sociocultural factors that contribute to their substance use (Lex 1991). Because men and women are socialized differently, women frequently have fewer assertiveness skills and need more supportive networks to remain alcohol- or other drug-free (Marsh and Miller 1985). In U.S. society, women's social status usually derives from men, and the drugs they use are often obtained from men (Boyd 1993). Often, female addicts report having been sexually abused (Wildwind and Samson 1981, pp. 109-163). Family substance abuse, sexual abuse, age of first depressive symptoms, and age of first illicit drug use have been found to be significantly correlated for women (Boyd 1993).

To be successful in drawing women into treatment, it is necessary to be cognizant of gender differences. Problems specific to many female substance abusers include low self-esteem (Reed 1990) and late entry into recovery that is often prompted by the criminal justice system or child protective service agencies (Haller 1991). A study of pregnant and postpartum women in substance abuse treatment facilities in the southeastern United States identified the major barriers faced by women enrolling in treatment as self-perceived rather than logistical or systemic in nature. Major barriers included issues such as fear of losing their children, shame, depression, and denial (Gehshan 1993). Women may fear that their partners will abuse them or leave them if they seek

treatment services (Center for Substance Abuse Prevention 1993). In addition to these self-imposed obstacles, other identified barriers include lack of money, waiting lists for treatment slots, limited service availability for pregnant women, lack of child care, unsafe housing, and lack of transportation (Gehshan 1993; Chasnoff 1993).

Women seek treatment for a variety of reasons, including family pressure, concern for their children, and pressure from the legal system (Gehshan 1993). Women have a host of problems that are different from the problems men face when attempting to enter treatment. Therefore, there are many reasons to believe that treatment services for substance-abusing women should be different from those for men. One of the most difficult aspects of treatment is identifying substance-abusing women and drawing them into care (Haller 1991). Active recruitment and outreach efforts are needed to help women overcome self-imposed barriers and enter substance abuse treatment programs. Programs should be designed to meet the needs of women.

In the State of Florida, as in many other States, it is illegal to use drugs while pregnant (Florida Statute 397), and substance-abusing women face the possibility of having their newborns taken away from them at birth if the infants have positive urine toxicology screens. As a result, pregnant substance abusers are often suspicious of the "system." Many access prenatal care late in their pregnancies or present at the time of delivery, having received no prenatal care because of that suspicion.

These parents often fear social service agencies, protective service personnel, strangers, talking about personal issues, and labeling (Kumpfer 1991, pp. 87-95). Nontraditional outreach methods using former addicts, aggressive outreach techniques, and immediate response may be effective in reducing preadmission hurdles (Brown 1991, pp. 1-26). Moreover, substance-abusing women frequently lack knowledge regarding treatment service availability and the means by which to access that service. This naivete, coupled with their fear of the system, often constitutes the principal barrier in getting them into a treatment center.

Environmental factors, such as single parenthood and lack of social support, may have a negative effect on an individual's ability to enter treatment (Freier et al. 1991). Most drug-using women face problems other than their addiction. They frequently have numerous financial, legal, health, social, and psychological problems, including poor housing, inadequate income, lack of education, and emotional difficulties. Sexual

or other physical abuse during childhood is common among these women (Regan et al. 1984, p. 330). In addition, many have histories that include abusive or violent relationships with men (Gehshan 1993).

Substance-abusing women with lower levels of self-esteem and higher levels of emotional distress have more difficulty participating in drug treatment and are pessimistic about the prospect of making positive changes in their lives (Reed and Moise 1979, pp. 114-128).

WHAT MAY WORK AND WHY

Substance-abusing women often view treatment as a way to avert the negative consequences of their drug use, such as loss of child custody or incarceration. Generally, they are ready to enter treatment only at a crisis point in their lives when they need stabilization. It is only after critical factors, such as housing, child care, transportation, and medical assistance, are satisfactorily provided that female addicts can focus on their addiction (Haller 1991). Assisting a woman in accessing these other services can help establish trust between her and her counselor or case manager. Special emphasis should be placed on the engagement of women at each step of the treatment entry process: outreach, referral, and intake (Longshore et al. 1993).

Providing women with preadmission intervention services that reduce real and perceived barriers to treatment and increase their ability to adjust to a program can help them follow through with treatment recommendations. Furnishing early intervention services to women who are on a waiting list for treatment can influence their willingness to enroll in treatment services (Katz 1963).

The provision of "up-front" case management services designed to help stabilize a woman and make the transition to treatment easier can increase retention rates (Haller 1991). Helping potential clients overcome fear means the development of a relationship of mutual trust and respect that often requires much time and effort. For example, if a woman is afraid that State intervention may lead to the loss of custody of her children, these fears might be overcome if she is provided with information about how such laws and program regulations affect her. Explaining the confidentiality regulations of the agency and the reporting requirements for child abuse and neglect in a way that demonstrates that the clinician has the program participant's welfare in mind can assist in establishing trust (Kumpfer 1991, pp. 87-95).

Children are an important force in the lives of addicted parents, either as a motivation to halt drug use or as an additional strain at a time when parents, particularly mothers, need to focus on their own needs for treatment. The provision of comprehensive services, before and during the enrollment period for substance abuse treatment services, has proven successful in dealing with personal problems of substance-abusing mothers. This outreach approach also facilitates the successful treatment of program participants, particularly mothers of small children (Eldred et al. 1974).

Moreover, a substance abuse counselor's or case manager's therapeutic style may affect treatment outcome. Clients of those counselors who possess "accurate empathy" generally have better treatment outcomes, and therapist empathy has been identified as a key element in successful brief interventions (Miller 1992). Empathy is the imaginative projection of one's own consciousness into another being to increase one's understanding of the other's situation. The amount of empathy received by the client is considered one of the most salient elements in the treatment relationship; lack of empathy frequently has led clients to prematurely withdraw from treatment (Katz 1963).

It also is vital that program staff members be trained to be "ethnically competent," defined as having the ability to conduct an individual's professional work so that it is comparable with the behavior and expectations that members of a culture recognize as appropriate among themselves (Green 1982). Characteristics of ethnic competence include having an awareness of one's own cultural limitations, being open to cultural differences, using cultural resources, acknowledging cultural integrity, and possessing a client-oriented, systematic learning style (Green 1982).

Operation PAR, Inc. (Parental Awareness and Responsibility), is involved in research and training in the area of maternal substance abuse and offers a continuum of services to a population of drug-abusing mothers that includes early intervention services, case management services, outpatient treatment, day treatment, short- and long-term residential treatment, detoxification services, and methadone maintenance. Operation PAR also provides early intervention developmental day-care services to children younger than 5 years whose mothers are Operation PAR clients. At Operation PAR, it is believed that female substance abusers who receive preadmission crisis intervention services

designed to facilitate their entry into treatment are more likely to enroll in treatment services.

The goals of the clinician are to reduce barriers and make clients feel at ease when entering treatment. A key component of this process is the establishment of an alliance between the clinician and the potential program participant. Confrontational techniques must be avoided. Confrontation is considered counterproductive in work with women (Underhill 1986). The objective is to establish rapport and then trust.

At Operation PAR, it is standard practice for a clinician to assist a woman in meeting any immediate crisis intervention needs such as housing, food, or clothing, before administering the Operation PAR biopsychosocial assessment. Once rapport has been established and the clinician is viewed as an advocate rather than an adversary, the assessment is conducted.

Operation PAR's philosophy is that clinicians must play a nonjudgmental advocacy role to assist women in accessing substance abuse treatment services. The prospective client must view the clinician as her advocate. This can be accomplished by assisting the woman with accessing any services she needs, such as child care, transportation, and medical care. After a basis of trust has been developed, a woman should be given a thorough biopsychosocial assessment that measures crucial life domain areas to determine the level and intensity of substance abuse treatment needed. She must be made aware of her treatment options; a tour of the treatment facility prior to enrollment often will assist in lessening some of her fears. It also is recommended that intervention workers provide followup contact and remain the woman's advocates until she is stabilized in treatment.

It is Operation PAR's philosophy that, ideally, female counselors should work with women. Although that is not always possible, it is crucial that women assist women in accessing substance abuse treatment services because men are often viewed as the perpetrators of the sexual and other physical abuse so many substance-abusing women have experienced (Burman 1992).

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