Retention Issues Involving Drug-Abusing Women in Treatment Research

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INTRODUCTION

Most drug treatment programs in the United States have been developed by men, on men, and for men. Although drug treatment has been available to women, it rarely has been based on women's special needs. As a partial consequence, fewer women than men receive drug treatment. Not only are women an underserved population, but they also experience greater problems with retention once they begin treatment.

Numerous barriers contribute to the high dropout rate of women from drug programs. Unfortunately, many drug agencies will not continue women in treatment when they become pregnant because of the agencies' inability to provide the prenatal and postnatal medical services and other special support services that pregnant and postpartum women need. Some agencies are concerned about the legal liabilities related to treating pregnant women, especially those who inject drugs and may be positive for the human immunodeficiency virus (HIV). Sedative-hypnotic withdrawal can be safely accomplished during pregnancy, but opioid withdrawal among pregnant women is controversial (Jarvis and Schnoll 1994). There is no pharmacologic treatment available to wean women from cocaine. However, despite the availability of medical treatment, many programs serving women have inadequate funds to support a medical staff.

ECONOMIC BARRIERS

Many drug-abusing women drop out of treatment because of economic problems. First, drug treatment is not always affordable to women, especially those on public assistance and those with few monetary resources who require treatment that is either free or inexpensive. Drug treatment, especially residential care, can cost thousands of dollars and may not be covered by medicaid. Women with alcohol or other drug addiction often find few places where they can seek treatment, and the agencies that are accessible to them usually have long waiting lists.

Second, adequate child care and transportation are critical for most women who have young children, work outside the home, and attempt to stay in drug therapy. In a demonstration study, the Phoenix, Arizona, project, the most frequent reasons given by women for discontinuing drug therapy sessions were the lack of child care and transportation. If the women work, they have low-paying jobs, often part time, with no flextime, no job security, and few or no health benefits (Lewis 1992).

When women are not only the mothers of young children but also the primary caretakers of elderly parents or disabled husbands or partners, they usually cannot enter, much less remain in, residential (inpatient) treatment programs. Significant others and nuclear family members may resist a woman's staying in residential (or even outpatient) treatment because this disrupts the family system.

LOGISTICAL BARRIERS TO RETENTION

Child Care Barriers

Lack of child care is a major barrier to many women continuing in drug treatment. Substance-abusing women who head single-parent households often have low incomes, unstable housing, and few social resources to help with child care. Unless drug programs provide child care services, many mothers are unable to continue in treatment. Providing onsite child care affords mothers not only the means to continue attending treatment but also the opportunity to learn parenting skills and improve parent-child bonding.

The Phoenix project's intensive outpatient program found that mothers could not find adequate, affordable child care (Lewis 1993) and that the women's husbands or partners were often unavailable or unwilling to provide the necessary child care during the women's 11 outpatient treatment hours each week. Many women had no other family members available to help care for their children. Sometimes, even when family help was available, women were reluctant to use that help because the resulting dependence could keep them involved in unhealthy ways with their families, especially if family members did not support the women's efforts toward recovery.

Retention of mothers in treatment was greatly improved in the Phoenix project once free babysitting services and transportation were provided to all women clients (Lewis 1993). In contrast, the Landover, Maryland, and Richmond, Virginia, projects provided child care for both their outpatient and residential programs from the beginning of the projects. These services

proved to be a significant factor in attracting clients because many women did not want to be separated from their children during treatment.

Many drug treatment agencies have no history of providing child care to their clients. In Phoenix, administrators were told that there were insurmountable obstacles to providing onsite child care. The process of obtaining State child care certification was long and expensive. However, if parents remained onsite during the babysitting service, the agency was not required to be licensed. Similarly, in the Richmond project at the Virginia Commonwealth University Center for Perinatal Addiction (CPA), onsite babysitting was provided when the mothers were onsite. However, this project became State licensed despite the bureaucratic obstacles.

Another impediment to providing affordable babysitting to the Phoenix mothers was that babysitting costs had not been requested in the original grant from the National Institute on Drug Abuse. Fortunately, project staff members eventually recruited a small cadre of community volunteers for babysitting. These efforts were quickly rewarded by noticeable increases in women's treatment retention (Lewis 1993).

In summary, Finnegan (1979, pp. 121-131), Beschner and Thompson (1981), and others, in describing the unique needs of women (especially pregnant women) in drug treatment, have strongly recommended providing child care, socialization and support skills for mother-child bonding, nursery services for high-risk infants born to substance-abusing mothers, parenting skills training, outreach, and followup care for mothers and children. In short, gender-sensitive programs that provide child care services have found that this option not only improves retention but also enhances the effectiveness of the program as a whole (Reckman et al. 1984).

Transportation Barriers

Lack of transportation also influences treatment retention for many women. Drug programs rarely are found in the women's own neighborhoods. Public transportation is not always provided in suburban areas, and traveling at night, even in one's own vehicle, can be dangerous. The cost of providing transportation for a mother and her children can be prohibitive, but providing clients with free or low-cost, door-to-door transportation often improves retention.

In the Landover project, a 15-passenger van was purchased to take clients to and from the outpatient program. A car telephone also was bought and found to be useful in alerting clients to the time that the van was arriving to pick them up. For those clients who did not have access to a telephone,

a scheduling pattern was established so that the women knew when to expect the van.

As a result of available transportation and other resources, the Landover project was viewed by its main client referral source as "the best game in town." This was because the women were not put on a waiting list, did not need medical insurance to participate, and were provided child care and transportation services to and from the treatment programs and even for home visits.

The Phoenix project, in contrast, inherited transportation problems characteristic of many large, urban agencies, namely, insufficient public transportation and great distances between a woman's community and the treatment center. Although a public bus system existed, greater Phoenix bus routes were relatively few. In addition, scheduled buses were often not available in the evenings when many mothers were free to attend treatment meetings.

Although several Perinatal-20 projects provided some clients with transportation by hiring or buying vans, the Phoenix project did not have such resources and therefore had to turn instead to buying bus tokens and developing relationships with taxicab companies through a voucher system for the occasional transportation of certain clients—women who were unable to pay anything toward their transportation to drug treatment. CPA also provided bus tickets for treatment-related transportation and taxicab vouchers for women in medical crises or in labor.

OTHER BARRIERS TO TREATMENT

Programs that create a user-friendly environment increase the likelihood that women will access available services and remain in treatment. However, child care and transportation are not the only factors that can influence treatment dropout for this population. Environmental, patient, and program variables also play roles.

Impoverished Environments—Housing

For example, during the 5 years of CPA's operation, the majority of patients came from impoverished environments characterized by high rates of drug use, crime, and family violence. As substance abuse clinicians know, individuals who are successful at recovery must frequently remove themselves from situations that place them at risk for relapse. However, this is a difficult task for addicted women who lack the necessary resources for independent living.

This problem was addressed through provision of "transitional housing" for addicted women entering intensive outpatient treatment at CPA. Housing was made available on a first-come, first-served basis to anyone whose circumstances warranted her separation from her home environment. This included women who had actively drug-using or abusive family members or partners and those who were homeless or living in shelters. Women were able to bring their children with them to the transitional housing unit (THU). In this way, families were kept together so that parenting skills could be taught and the foster placement of project children could be avoided. The women who received transitional housing services also obtained enhanced case management from residence staff members who assisted them in locating permanent, safe, drug-free housing. Aside from their limited stay in the THU (during pregnancy and up to 3 months postpartum), these women received the same medical, psychotherapeutic, and support services (child care and transportation) as those in intensive outpatient treatment.

Two studies on the housing variable were conducted by the Richmond project (Haller et al., in press; 1993, p. 303). In both studies women's retention rate was positively influenced by their residing in the program operated by the THU. In the first study (n=48), only 20 percent of those not receiving housing services were still in the program at the 60-day mark compared with nearly 60 percent of those residing in the THU. In the second study (n=52), the dropout (survival) curve leveled off at 50 percent after 80 days in treatment for those living in the THU, whereas it plateaued at 20 percent at day 60 and then fell to 10 percent by day 120 for those not living in the THU. The relative risk for dropout for those living in the community was 2.21 times that of those living in the THU. It should be noted that, from a clinical perspective, the THU is an obvious "draw" to the clinical programs, facilitating recruitment as well as retention. Therefore, the waiting list for acceptance into the THU tends to be long. However, those women scheduled for admission to the THU are more likely to start treatment than are those not expecting to enter the THU.

The problem with this finding is that such supervised, drug-free housing for addicted pregnant women and their children is expensive and not typically available. In addition, once women are ready to leave the THU (even while they remain engaged in intensive outpatient treatment), they cannot find acceptable housing within the community. Most subsidized housing units are located in undesirable neighborhoods. The prospect of returning patients to their pretreatment living environment is equally unacceptable. Those who return home are viewed as being at higher risk for relapse and treatment dropout. Accordingly, followup housing was given much attention in the CPA program. Staff members considered it

to be the patients' primary problem. Residence staff members and case managers now work with various community agencies to create housing opportunities for their patients to secure their continuation in treatment and to sustain recovery. The recommendation of staff members is for drug treatment programs to form partnerships with local housing authorities that will establish facilities (group homes, shared apartments, etc.) specifically for perinatal patients and their dependents. This allows the agencies to work cooperatively with CPA and with women who are actively engaged in a recovery program.

Patient Barriers

Self-Volunteers vs. Court Referrals. The patients' legal status also may affect retention. Interagency cooperation is frequently important for women drug abusers who are involved with the criminal justice system. Several studies of substance abusers have found legal coercion to positively affect retention (Collins and Allison 1983; McFarlain et al. 1977). Recently, CPA discovered that those with a "clear" legal status were more likely to become treatment dropouts than those who were either on probation or parole or who had court dates pending (Haller et al. 1993, p. 303). The survival curve for those with legal involvement suggested that about 40 percent of these patients were retained through day 220. In contrast, only about 10 percent of those not involved in the legal system were retained by day 120. Although CPA did not accept court-mandated patients, it did take those who were court referred. Often, these women knew that they would be jailed if they dropped out of treatment. Therefore, the positive influence of legal involvement suggests that treatment providers who wish to be successful (and those interested in the recruitment and long-time retention of research subjects) should align themselves with the courts and legal system.

Patient Demographics. Although several demographic factors have been found to influence the treatment retention of substance abusers, findings have varied among populations and studies. Of particular relevance are findings that women as a group (Sansone 1980) and unemployed, single African-American women who are polysubstance abusers (Steer 1980) have lower treatment retention rates.

In the Richmond project, researchers identified several demographic variables that seemed to predict retention. For their sample of mostly female, single African-American cocaine/marijuana/alcohol/nicotine users, age and number of prior treatment attempts were associated with retention, whereas educational level and neighborhood quality (with regard to crime and drugs) were not (Haller et al. 1993, p. 303). Younger patients and those who were inexperienced with treatment were more likely to leave

treatment prematurely. Indeed, nearly 60 percent of those older than age 29 were retained at day 200, whereas all patients younger than 23 years had dropped out by day 120.

In the Landover project, clients younger than 26 years were most likely to drop out of the project compared with the 26- to 30-year-olds or those older than 30. Sixty-eight percent of those younger than 26 years old remained in the project by the sixth month (n=42, p=0.007), and 89 percent of the 26- to 30-year-olds remained in the project by the sixth month (n=30, p=0.002). Interestingly, 70 percent of the older-than-30 clients remained in the project; however, this was not significant. Clients younger than 26 were more likely to leave treatment by the sixth month of participation than were clients ages 26 to 30, who were most likely to remain.

Similarly, CPA found that nearly 60 percent of those with three or more prior treatment episodes were retained at day 200 (no dropout was evidenced after day 60), whereas all the first-time patients had left treatment by day 60. It may be that the younger, more treatment-naive patients had not suffered sufficient consequences of addiction to convince them of the need for intensive treatment. For those in treatment for the first time, the program may have been viewed as too restrictive. These findings are of particular importance because treatment-matching based solely on clinical need may fail if age and number of prior treatment attempts are not taken into account. Thus, even if a woman is deemed to need intensive treatment, it might be necessary to make adjustments in the recommended treatment plan to maintain her in the treatment delivery system.

One additional predictor of retention in the CPA project seemed to be a woman's particular pregnancy trimester. For instance, those who were admitted to CPA in their first trimester were least likely to drop out, whereas those who had entered postpartum were most likely to leave treatment prematurely. Of those who entered treatment early in pregnancy, 60 percent were retained, compared with fewer than 10 percent who entered postdelivery. This suggests the need to recruit pregnant addicts into treatment as early as possible when motivation to remain drug-free through the rest of the pregnancy is greater.

Program Barriers

Detoxification. The Phoenix project spent considerable effort examining various program-related barriers to the retention of women in its outpatient treatment program. An analysis of the women's attrition, by stage of treatment, revealed numerous sources of attrition over time. First, only slightly more than one-third (38 percent) of the Phoenix women who received an intake interview into the project completed 1 or more weeks

of drug detoxification and proceeded into the next treatment phase, despite the provision of free detoxification services for all women who needed them.

Fortunately, high relapse rates were not grounds for research staff apathy. Instead, concerted efforts led to increasing client-friendly measures for all project women during their detoxification experience, including one-on-one contact by a specified counselor instructed to give personal attention and support to each woman passing through the outpatient detoxification laboratory. These supportive efforts by the counselors seemed to account for a decided increase in retention at this stage. That is, there was a 24-percent improvement in retention over the first year.

Waiting List Barrier. Only 42 percent of women entering the Phoenix project and successfully completing detoxification during the first year were retained long enough to remain through the waiting list period and finally be assigned to a group for drug abuse therapy and perhaps couples therapy.

The waiting period was much shorter than the typical 1 to 6 months for women who requested drug abuse therapy in the first agency to cooperate with the Phoenix project. The agency provided a pretherapy introduction program (group socialization program) for those awaiting therapy instead of the typical no-therapy waiting list. However, it was apparent that even a waiting period of a few weeks reduced the list of women who had requested treatment. Therefore, the Phoenix project hired a female intake worker/counselor who spent substantial time "joining with" the women immediately after their intake or detoxification. She nurtured them throughout the weeks they attended the pretherapy orientation meetings while they waited for a slot to open in a drug treatment group. This female counselor made weekly contacts with each woman and served as a supportive resource. The researchers discovered that this additional supportive effort kept some of their women clients from dropping out during this early stage of pretreatment. In quantitative terms, during the second year of its use, Phoenix project retention rates were nearly doubled (a 44-percent improvement over the first-year retention rate) after the supportive efforts of pretherapy treatment were initiated (MacDermid et al. 1994).

Gender-Sensitive Programming. During the second year of the Phoenix project, the research team instituted more gender-sensitive programming, including the provision of babysitting and transportation. The team also considered the option of offering women-only drug treatment groups at the cooperating agency because it was apparent that some women were not comfortable in coeducational therapy groups.

As one of the women told the program coordinator, "I just cannot relax being around so many men who have extensive body tattoos." The idea for this option came from the suggestions of several women clients who thought that more of their special needs could be met in a women-only treatment group. However, administrators at the agency had concerns about developing such groups. In particular, they were worried that a women-only group would draw women away from their existing coeducational groups. In lieu of developing women-only groups, the research team worked with the agency's administration to provide an additional treatment group that would meet in the evenings. This new mixed-sex treatment group quickly provided many new treatment slots for women who had been unable to attend daytime programs and apparently helped increase the retention of many women clients (MacDermid et al. 1994).

CONCLUSIONS

Staff Suggestions

In the CPA project, a meeting of the entire staff (including psychiatric nurses, social workers, psychologists, substance abuse counselors, residence staff members, and child care staff members) was held to summarize the major retention barriers for women and offer solutions for these problems. According to meeting attendees, the single most important factor for aiding the retention of women was adequate housing (both during and after treatment). The therapists' top priority on a "wish list" was for the city to develop low-income, semisupervised, recovery-oriented housing (such as Oxford House, a self-governed, aftercare house for persons in recovery) that could accommodate female addicts and their children on a long-term basis. Currently, the only Oxford House is costly and does not permit children. Ideally, facilities would also provide cooperative child care. Thus, a 2- to 3-year stay in such housing would help an addicted woman complete her education, begin a viable career path, and become self-sufficient, ultimately breaking the cycle of dependence on society, improving the individual's self-esteem, and maintaining her sobriety.

The second recommendation to prevent dropout was to provide child care for all treatment-related activities, which the CPA project had been doing. Offering clinical services to addicted mothers without offering child care was considered "ludicrous" and "unrealistic" by CPA staff members. Providing child care sends several messages: that the treatment team acknowledges the patients as mothers, values them and their children, understands and accepts the context of the mothers' lives, and understands that treatment for women needs to be different from treatment for men.

However, housing and child care are both expensive to provide. Therefore, CPA staff members also recommended many less costly but meaningful additional incentives for retention. For example, the staff members described perinatal substance abusers as deprived, both emotionally and materially. Because the women have a history of impoverishment, tangible things are meaningful to them. One therapist thus recommended that perinatal addiction programs give frequent material incentives. Specifically, staff members recommended providing women with material items that meet real needs but that carry therapeutic messages as well. For example, condoms should be distributed freely and frequently throughout the treatment week. Practically, these protect against pregnancy and sexually transmitted diseases, including HIV. Metaphorically, they indicate that CPA staff members value the women and want to help protect them.

Another recommendation was that new patients be given an appointment calendar on the first day of treatment, a calendar similar to those kept by many professionals. Practically, the calendar can help to orient an addict to her treatment schedule and help her to learn to better organize her time and appointments. Metaphorically, the calendar says "You belong somewhere and are important enough to have a schedule of appointments." The calendar serves an additional function if it is filled with affirmations, for example, 12-step sayings or spiritual encouragements.

One suggestion, which was debated among staff members, was to provide hot lunches to participants and their children on treatment days. All staff members agreed that providing meals would likely enhance retention; however, some members were concerned about possible unintended effects. That is, some staff members felt that, even if women attended treatment merely to be fed, this would afford them a better chance of staying in recovery. Others felt that feeding patients would foster overdependency and passivity.

Finally, staff members recommended that treatment programs employ some personnel who are in recovery. This can enhance an addict's perception that the therapists understand them because of common experiences. Similarly, employing staff members of representative ethnic backgrounds also was seen as important in providing a welcoming atmosphere and role models for the achievement of recovery.

Overall, the multidisciplinary staff at CPA felt that the provision of housing and child care was essential to retaining perinatal substance abusers in treatment. In addition, they recommended providing tangible items to patients as a means of reducing dropout and enhancing participation in

treatment. The gift items were seen as having both practical and symbolic value.

Recommendations for Programs

This chapter reviews the barriers to retention of women in drug treatment programs. Many of these barriers are economic or logistical (housing, child care, transportation), patient related (legal status, age, experience with treatment, stage of pregnancy), or program related (availability of medical detoxification, gender-sensitive vs. generic treatment, waiting lists). To avoid the grim but common attrition of women in drug treatment, the authors recommend the following: Drug treatment programs should anticipate and meet the special, multiple needs of women, be affordable, be client friendly, and be gender sensitive and culture sensitive.

REFERENCES

Beschner, G., and Thompson, P. *Women and Drug Abuse Treatment: Needs and Services*. National Institute on Drug Abuse Services Research Monograph Series. DHHS Pub. No. (ADM)81-1057. Rockville, MD: National Institute on Drug Abuse, 1981. 25 pp.

Collins, J.J., and Allison, M. Legal coercion and retention in drug abuse treatment. *Hosp Community Psychiatry* 34(12):1145-1149, 1983.

Finnegan, L.P. Women in treatment. In: DuPont, R.L.; Goldstein, A.; and O'Donnell, J., eds. *Handbook on Drug Abuse*. Rockville, MD: Department of Health, Education, and Welfare, Alcohol, Drug Abuse, and Mental Health Administration, National Institute on Drug Abuse, 1979.

Haller, D.L.; Elswick, R.K., Jr.; Dawson, K.S.; Knisely, J.S.; and Schnoll, S.H. Retention in treatment of perinatal substance abusers. In: Harris, L., ed. *Problems of Drug Dependence, 1992: Proceeding of the 54th Annual Scientific Meeting. The College on Problems of Drug Dependence, Inc*. National Institute on Drug Abuse Research Monograph 132. NIH Pub. No. 93-3505. Washington, DC: Supt. of Docs., U.S. Govt. Print. Off., 1993.

Haller, D.L.; Knisely, J.S.; Elswick, R.K., Jr.; Dawson, K.S.; and Schnoll, S.H. Perinatal drug abusers: Substance abuse treatment. Some factors influencing treatment retention. *J Subst Abuse Treat,* in press.

Jarvis, M.A., and Schnoll, S.H. Methadone treatment during pregnancy. *J Psychoactive Drugs* 26(2):155-161, 1994.

Lewis, R.A. “Barriers to the Treatment of Women Drug Abusers.” Keynote address to the annual meeting of the Ohio chapters of the American Association for Marriage and Family Therapy, National Council on Family Relations, and Sex Information and Education Council of the United States, Dublin, OH, September 25, 1992.

Lewis, R.A. “Overcoming Barriers to the Treatment of Drug-Abusing Women.” Paper written for the Central European Conference on Women, the Family, and Social Change. Warsaw, Poland, and Prague, The Czech Republic, May 16-22, 1993. 21 pp.

MacDermid, S.; Dickey, M.; and Lewis, R. “Clients’ Attendance as a Function of Women’s Retention in Drug Treatment Programs.” Unpublished manuscript, Purdue University, 1994. 29 pp.

McFarlain, R.A.; Cohen, G.H.; Yoder, J.; and Guidry, L. Psychological test and demographic variables associated with retention of narcotic addicts in treatment. *Int J Addict* 12(2-3):399-410, 1977.

Reckman, L.W.; Babcock, B.G.; and O’Bryan, T. Meeting the child care needs of the female alcoholic. *Child Welfare* 68:541-546, 1984.

Sansone, J. Retention patterns in a therapeutic community for the treatment of drug abuse. *Int J Addict* 15(5):711-736, 1980.

Steer, R.A. Psychosocial correlates of retention in methadone maintenance. *Int J Addict* 15(7):1003-1009, 1980.

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