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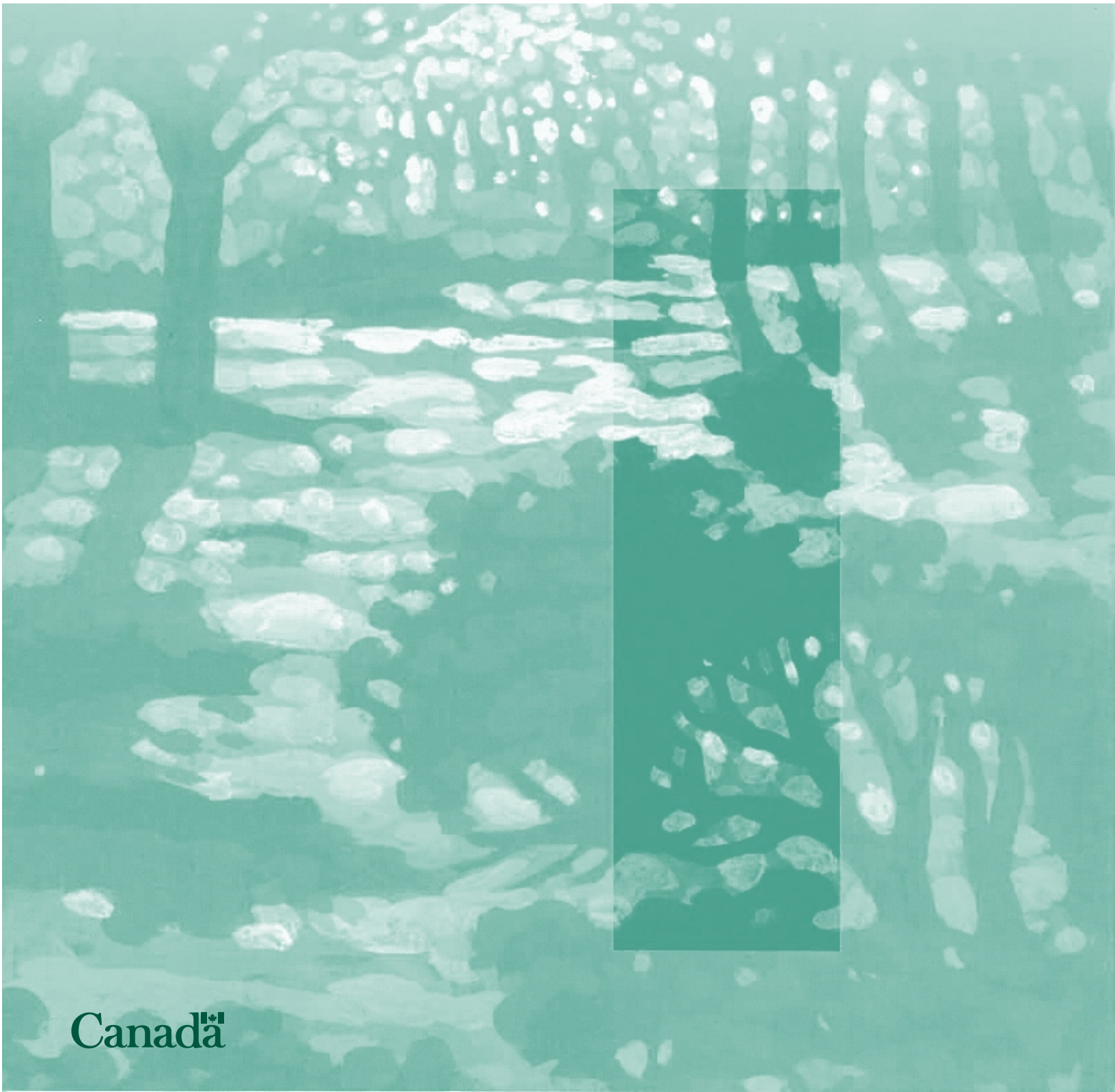
Health Canada Santé Canada

Best Practices

Treatment and Rehabilitation for Women with Substance Use Problems



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Best Practices
Treatment and Rehabilitation for Women with Substance Use Problems

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Health Canada

canada's drug strategy

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Report Overview

This report identifies elements of best practice in the treatment and rehabilitation of women with substance use problems. Best practices are identified and described in the areas of: client outreach, contact and engagement, treatment principles, specific approaches and methods, client retention in treatment, treatment organization and duration, delivery of adjunctive services, and measurement of treatment effectiveness. Recommendations for best practices are based on the results of interviews with 40 key experts and a review of current literature related to these topic areas. Interviews with key experts and the review of the literature also addressed barriers to treatment for women.

The report briefly summarizes patterns and impacts of women's substance use. Characteristics of specialized population groups, such as pregnant and parenting women, Aboriginal and ethno-cultural minority women are also described.

Personal, interpersonal, societal and program-related barriers applicable to women requiring treatment are identified. Shame and guilt, fear of being isolated and of losing children, program limitations such as inadequate referral and outreach, and the limited availability of cost-free, flexible programming are some of the general barriers identified.

A range of specific barriers to treatment are described as applying to specialized population groups. For example, pregnant and parenting women are more affected by structural (lack of child care services) and personal (fear, guilt and shame which are intensified by the social stigma attached to mothers who use substances) barriers. Ethno-cultural women appear to be more affected by socio-cultural structures and beliefs which discourage acknowledgement of substance use disorders or utilization of formal helping systems.

The report describes 13 underlying principles of treatment, including the importance of offering a menu of treatment and related support options, the value of an approach that considers all aspects of a woman's life, including emotional, psychological and spiritual elements, and approaches that are women-centered, empowering and support connections between women.

The importance of addressing interrelated health issues, a gender-sensitive approach, client education, the value of using a "relational" model of treatment, a practical skill-building orientation, addressing family issues, a harm reduction approach, and a realistic view of relapse prevention and management are some of the treatment methods and approaches identified as best practices by key experts and within the literature.

Although the literature related to basic organization or structure of treatment is inconclusive, key experts, in general, prefer out-patient settings with residential treatment being available for women with more severe problems of long duration or those living in unsafe environments. There was consensus that the establishment of optimal treatment duration is dependent on careful assessment of client needs and matching clients to the range of treatment options, including brief treatment which has been found to be an effective approach for some women.

The report also identifies adjunctive services most critical to women's treatment and recommends structures for delivering these services.

Finally, the report addresses the issue of the measurement of treatment outcomes and effectiveness. Both the literature and key experts suggest that treatment "success" needs to be viewed and measured in a multi-dimensional way using a range of "quality of life" measures, client self-assessment, as well as reductions in substance use.

Summary tables of key expert-identified best practice elements are included in the report.

This report is organized into two main sections. Section I provides an introduction and background to the project, including study definitions, parameters and limitations of the project. Section II provides the results of the project, including results of both key expert interviews and outcomes of the literature review. Each sub-section is organized by topic area. Both key expert opinion and summaries of the available literature are presented within each of the topic areas.

Section I: Project Background and Description

1. Introduction and Organization

1.1 Introduction and Background

This project on best practices related to substance abuse treatment for women was initiated by Health Canada as part of a three-year research agenda approved by the Federal/Provincial/Territorial Committee on Alcohol and Other Drug Issues.

The project was carried out under the direction of an advisory committee: the Working Group on Accountability and Evaluation Framework and Research Agenda of the Federal/Provincial/Territorial Committee on Alcohol and Other Drug Issues. The mandate of the working group is to develop recommendations for an accountability and evaluation framework for the Alcohol and Drug Treatment and Rehabilitation (ADTR) Program and to oversee the development and implementation of a research agenda which would stimulate innovative substance abuse treatment and rehabilitation programs by identifying best practices, evaluating model treatment and rehabilitation programs, conducting research on emerging issues, and disseminating leading-edge information across the country.

This project is being undertaken simultaneously with another project on best practices for the treatment and rehabilitation of youth with substance use problems. Both projects build on initial work undertaken by Health Canada in collaboration with the provinces and territories to address best practices in treatment and rehabilitation published as: *Best Practices – Substance Abuse Treatment and Rehabilitation* (Health Canada, 1999).

1.2 Organization

This report is organized into two main sections. Section I provides an introduction and background to the project, including project definitions, parameters and limitations. Section II provides the results of the project, including results of both key expert interviews and the literature review. Each sub-section is organized by topic area. Both key expert opinion and summaries of the available literature are presented within each of the topic areas.

2. Project Goals and Objectives

The overall goal of this project is to:

- make available across Canada current information on best practices in the treatment and rehabilitation of women with substance use problems.

The objective is:

- to define evidence-based "best practices" and key components and supports in providing treatment and rehabilitation programs for women.

Within this overall framework, the project addressed the following specific questions:

- What are the barriers which affect women's access to or use of treatment?
- What are the best practices leading to the most successful outcomes in the following broad areas related to treatment?
  - client outreach, contact and engagement;
  - overall treatment values and philosophy;
  - specific treatment approaches (to address physical, personal and interpersonal issues);
  - retention of clients in treatment;
  - relapse prevention/management;
  - structure of treatment (duration, intensity, organization);
  - integration of relevant support services.
- What is the most relevant, realistic and effective way of measuring treatment "success?"
- What are the elements of a model treatment program for women?

3. Sources of Information

The project used two primary sources of information to identify best practices related to women's treatment. These were:

- comprehensive interviews with key experts involved in or relating to women's treatment;
- a focussed review of recent literature describing the elements of women's treatment most likely to result in positive outcomes.

These sources are described in detail below.

3.1 Key Expert Interviews

3.1.1 Identification and Characteristics of Key Experts

Key experts were initially identified by members of the federal/provincial/territorial advisory group to the project and recommended on the basis of their familiarity with a broad range of women's treatment approaches and expertise in identifying optimal elements of treatment. Key experts comprised:

- clinicians working directly with women undergoing treatment;
- administrators and related staff delivering women's treatment;
- provincial/federal/territorial government program and policy managers.

Forty alcohol and drug treatment experts participated in the interviews. They represented all areas of Canada, with the exception of Newfoundland and Yukon. Several key experts from the United States were also interviewed.

Key experts represented a variety of backgrounds, most were directors or coordinators of programs. The location and notes of key experts are shown in Tables 1 and 2.

Table 1: Geographical Distribution of Key Experts

Location	Total Number Of Key Experts
British Columbia	10*
Alberta	5
Saskatchewan	1
Manitoba	4
Ontario	6
Quebec	2
Nova Scotia	1
New Brunswick	2
Prince Edward Island	1
Northwest Territories	3
United States	5
Total	**40**

* Opinions of three B.C. key experts were amalgamated into one response.

Table 2: Role of Key Experts: Women's Best Practice Study

Role	Number of Key Experts
Treatment provider/Counsellor	11
Director of treatment program	16
Clinical or policy consultant	7
Researcher/Academic	5
Other (related service provider)	1
Total	**40**

A range of treatment organizations was represented in the study. The types of programs represented by clinicians and program directors are described in **Table 3**.*

Table 3: Types of Organizations Represented: Women's Best Practice Study

Type of Program	Number of Key Experts
Primarily detox programs	1
Multi-level programs (residential and out-patient) (in some cases includes detox)	11
Primarily residential	5
Primarily out-patient	7
Intensive day program	3
Policy and program development (range of services)	7
Other (e.g. research) range of services	6
Total	**40**

3.1.2 Key Expert Interviews: Methodology

Key experts were interviewed by telephone using a detailed interview format consisting of qualitative questions. The interviews identified:

- The needs of women and barriers to their accessing treatment;
- Best practice protocols, principal approaches and practices in each of the following substantive areas:
  - client outreach, contact and engagement
  - client retention
  - treatment values and philosophy
  - treatment approaches (to address physical health, personal and interpersonal issues)
  - relapse prevention
  - structure of treatment (duration, intensity, organization)
  - integration of additional support services.

The interviews also addressed:

- The most relevant, realistic and effective way of measuring "success" for women in treatment;
- Elements of a model treatment program.

* Only broad descriptions of programs were provided by respondents.

Key experts were given the opportunity to explore each question in depth, according to their own knowledge, expertise and background. Not all key experts responded to each question. In three cases, key experts requested to be interviewed in a group. Group responses were amalgamated into a "single" respondent response.

Quotes from key experts are used extensively throughout this document to illustrate or enlarge upon key issues. Quotes retain the vocabulary and emphasis of key experts.

3.1.3 Interview Length and Process

Potential key experts were initially contacted by telephone. A fax was then sent explaining the background, purpose and content of the interview in more detail. The interviews ranged from 45 minutes to 2 hours in length; average interview length was approximately 1 hour 20 minutes. A fax was sent after the completion of each interview thanking participants for their participation.

3.2 Literature Review

3.2.1 Parameters

A focussed literature review, primarily involving recent (post 1990) literature, was carried out in order to a provide a research-based perspective related to the topic areas defined above (Section 2.0). The literature review was not intended to provide an extensive overview of the experiences, issues and outcomes of women in treatment. While some general information is provided on patterns of use or characteristics of women misusing substances, this is provided only as background material. The review was based on sources that summarize research and evaluation data which identify best practices. Sources included:

- surveys of women's treatment outcome research;
- comparison studies of programs using differing approaches or methods;
- program evaluation data (summaries of evaluation research);
- research consultation with key experts and treatment providers.

The available literature has a number of limitations. These include:

- Some alcohol and drug treatment outcome literature is characterized by a range of methodological problems, such as inadequate design, non-random assignment, lack of "no-treatment" control groups, and poor client and substance use baseline data (Eliany and Rush, 1992). Where methodological problems are apparent, these are cited; however, it was not possible to substantially critique the reliability or validity of the sources used.

- Gaps were found in the literature, particularly in relation to the needs and experiences of specialized populations. Other gaps were found in the areas of optimal program structure and duration of treatment and the comparative value of different treatment approaches or methods.
- There are a limited number of empirical studies that demonstrate the effectiveness of one treatment approach for women over another, although there is strong theoretical and experiential support for certain models or directions.
- Most of the literature cited in this report relates to best practices oriented to broad alcohol and drug use rather than to specific substances (e.g. cocaine, barbiturates). Again, literature with this degree of specificity appears to be lacking.
- In some areas (e.g. optimal treatment duration and setting), research related to men and women is included if women-specific literature is lacking.

3.2.2 Initial Literature Sources

A variety of resources, broad-based bibliographic and specialized bibliographic searches were used to produce the initial reference resources for the literature review. These included:

- Canadian Centre on Substance Abuse: Specific bibliographic search on women alcohol/drug treatment;
- National Institute on Drug Abuse: Annotated (topic-focussed) bibliography, NIDA research abstracts (bibliography);
- Search of PREV line abstracts: National Clearinghouse for Alcohol and Drug Information;
- Search of NEDTAC (National Evaluation Data and Technical Assistance Centre);
- Uncover (Document Access Service): Key word search;
- Lindsmith Centre Library Database Search;
- A variety of generic studies produced by Canada's Drug Strategy Division, Health Canada and the Addiction Research Foundation (now a division of the Centre for Addiction and Mental Health).

4. Project Parameters and Definitions

4.1 Groups with Special Needs

This project focusses on the barriers to treatment and best practices involved in the effective treatment of women in general. Key experts were also asked to identify best practices in relation to the following groups with specialized needs. The groups defined by the project authority were women who are:

- pregnant and parenting;
- Aboriginal;
- members of ethno-cultural minority groups;
- injection drug users;
- women living with HIV/AIDS and Hepatitis C;
- experiencing concurrent disorders;
- in prison or involved with the criminal justice system;
- living in rural communities;
- isolated and/or homeless.

With the exception of the section on barriers to treatment (where respondents made specific comments related to these groups), in most cases key expert comments applied to all of the specialized groups. Where group-specific best practices are identified, these are noted in the text.

The terms of reference for this project did not address the treatment barriers or needs of specialized groups such as the elderly, women with disabilities or lesbians. A number of key experts who participated in the project emphasized that lesbians face unique personal, societal and program barriers and require a somewhat specialized treatment environment and approach. However, the needs and experiences of this group were not explored systematically with key experts.

4.2 Project Definitions: Treatment and Best Practice

4.2.1 Treatment

For the purposes of this report, *treatment is defined as an organized set of approaches and strategies which assist clients to reduce or eliminate problematic use of alcohol or drugs and which support healthy personal and interpersonal functioning.* Although the term "drug and alcohol treatment" implies a single entity, in fact, it includes a complex and variable network of services. As defined in *Canada's Drug Strategy* document, treatment and rehabilitation services in Canada include:

> detoxification services, early identification and intervention, assessment and referral, basic counselling and case management, therapeutic intervention, aftercare and clinical follow-up. Treatment is offered on an out-patient, day-patient or in-patient basis, including short-term and long-term residential care.
> (Health Canada, 1998:9)

4.2.2 Best Practice

The definition of best practice as it relates to program delivery in the health field has been approached with varying degrees of rigour. Within health care, the application of the idea of "best practice" has ranged from simply publishing particular practices under the rubric of "best," . . . to engaging in a systematic identification of what would constitute "best" within a particular health issue or practice area, . . . to a rigorous research-based investigation to identify evidence associated with particular practices, (Varcoe, 1998:4). For the purposes of this project, *best practice is defined as a consensus of key expert opinion on the approaches and elements of treatment which appear to result in the most successful treatment outcomes for women*. Using this definition, best practice is clearly based on key expert experience, judgment and perspective. The literature review provides further support to the views and conclusions of key experts.

4.3 Definition of Consensus Response

In order to capture the major themes, a "consensus response" was considered to be one in which at least four key experts (not from the same organization) were in agreement. A stronger degree of consensus is indicated in the text. Some opinions and recommendations with less support are included if they illustrated or expanded upon a major theme. Due to the open-ended nature of the questionnaire and the fact that answers were not probed to *achieve* consensus, exact numbers of key experts reporting are indicated for each response.

Section II: Results

5. Women's Substance Use and Misuse: Overview

5.1 Historical Background

Historically, substance use patterns among women have varied and the societal interpretation of these patterns has had impacts on attitudes toward women's use of substances as well as on treatment responses. In the 17th and 18th centuries, Cooper (1991) noted that alcohol was consumed by men, women and children and was not considered morally "wrong" or dangerous. In the 50-year period from 1776 to 1826, North American society's view of drinking changed; alcohol came to be considered "demonic" and unsafe. By the end of the 19th century, drinking was deemed a "lower class" activity and, among women, was associated with prostitution or "loose morals." However, alcohol and certain drugs were still included in commonly-used medications well into the 20th century (Hewitt et al., 1995).

Until the mid-1970s, the extent of heavy drinking among women in general was considered to be minimal, and there was a paucity of research exploring substance misuse. For example, "between 1970 and 1984, women represented only 8% of subjects in alcoholism studies" (Cooper, 1991:1). Though, in comparison with men, women are less likely to report heavy drinking occasions and alcohol-related problems (36% of those reporting alcohol-related problems are women) (Canadian Centre on Substance Abuse and Centre for Addiction and Mental Health, 1999), there are still concerns that women are under-represented in substance abuse treatment settings. In the 1980s, women made up only 20% of clients in treatment.

The emphasis on male substance use patterns and treatment for men has resulted in a "male as norm bias," which has judged women who require treatment more harshly, and has limited the exploration of gender-specific treatment approaches (Finkelstein et al., 1997).

5.2 Use Patterns

Recent Canadian research (Health Canada, 1995; Health Canada, 1997, Canadian Centre on Substance Abuse and Centre for Addiction and Mental Health, 1999) identifies the following patterns of substance use among women.

- Alcohol is the most common substance used and misused by women.
- Women, in comparison with men, are less likely to be current drinkers, and more likely to be former drinkers or lifetime abstainers.

- Women who are current drinkers drink less frequently and consume smaller amounts than men who are current drinkers.
- The proportion of women who completely abstain from alcohol is decreasing.
- Among women who are current drinkers, 6.2% report the occurrence of an alcohol-related problem in the past year.
- The most common problem women associate with "problem" alcohol use is related to impacts on physical health.
- Women most frequently drink with a spouse or partner.
- Women who drink a higher number of drinks per occasion tend to:
  - be younger;
  - have lower educational attainment;
  - have lower incomes;
  - be single or divorced;
  - be unemployed, a student or in a blue collar job.

- Women who report drinking more frequently tend to:
  - be older;
  - have higher educational attainment;
  - have higher incomes;
  - be single or divorced;
  - hold blue collar or managerial positions.

- In any age group, women are more likely than men to report the use of medications, especially psychoactive medications such as sleeping pills, tranquillizers and anti-depressants. The age categories reporting the heaviest use are 45 to 54 and 65+.
- Marijuana and hashish are the most common drugs used illegally by women.
- Except for marijuana, lifetime illegal use of drugs is relatively rare among Canadian women. Illegal use of drugs decreases with age and is almost non-existent after age 45.
- Cocaine, crack, LSD, amphetamines and heroin are used primarily by sub-group populations (e.g. street involved women). Because general population surveys usually miss these groups, the overall use of these drugs may be under-reported.
- In 1995, there were 804 deaths in Canada attributable to illicit drugs. One hundred and eight (13%) were women.

5.3 Impacts of Substance Use on Women

Substance use impacts on women in a variety of ways, many unique to gender. A review of the literature suggests the following general themes:

- **The physical health of women is affected more severely and in a shorter period of time by intensive substance use** (in comparison to men). Women reach higher peak blood alcohol levels than men from equal doses per pound of body weight. Hill (as cited in Schliebner, 1994) reported that "the average duration of excessive drinking before first signs of liver disorders, hypertension, obesity, anemia, malnutrition, gastrointestinal hemorrhage and ulcers requiring surgery is much shorter for women than for men (1994:513). Other health effects include risk of HIV, osteoporosis and coronary disease (Finkelstein et al., 1997). Physiological differences between men and women also make women more vulnerable to health effects of other drugs such as tobacco and benzodiazepines (Addiction Research Foundation, 1996).

- **Women's reproductive physiology is uniquely affected by substance misuse.** Excessive drinking can affect the menstrual cycle, fetal development, child birth, menopause and sexual responsiveness (Finkelstein et al.,1997).

- **Among women, mental health disorders are commonly associated with and exacerbated by intensive substance use.** Almost two thirds of women alcoholics have mental health problems (Halzer and Pryabech as cited in Beckman, 1994b). The most common disorders are anxiety, depression, phobias and panic disorders. Women alcoholics also report experiencing more depressive symptoms than male alcoholics physiologically (although alcohol itself has a depressant effect). However, depressive symptoms may persist after sobriety (Turnbull and Gomberg as cited in McCrady and Raytek, 1993).

- **Women who misuse substances are at high risk for suicide ideation and completion** (Finkelstein, 1997).

- **Women who misuse substances commonly experience sexual dysfunction.** Prevalence estimates of sexual dysfunction range from 20% to 100% depending on research (Acherman as cited in Beckman, 1994b). According to Wilsnack et al. (as cited in Finkelstein et al.,1997), sexual dysfunction in women is one of the strongest predictors of continued problem drinking. Impacts of substances on sexual functioning may vary according to the substances used.

- **Women who misuse substances typically experience low self-esteem** (Gomberg as cited in Drabble, 1996).

- **Other health disorders are associated with women who misuse substances.** Eating disorders, particularly bulimia, frequently occur concurrently with alcohol problems (Peverler and Fairburn as cited in McCrady and Raytek, 1993).

Specific characteristics appear to be associated with women who misuse alcohol or drugs. These are causative, rather than associated factors:

- **High rate of childhood sexual abuse.** The rate of historic sexual abuse is higher in women with drinking problems than in the general population. Estimates of the prevalence of incest, for example, range from 12% to 31% (Young, 1990; Beckman and Acherman as cited in Beckman, 1994b).
- **High rate of victimization.** Women who misuse alcohol are likely to have had a history of victimization in general (including physical violence) (Thom, 1986 and Smith, 1992 as cited in Schober and Annis, 1996). In a study of 472 women (ages 18 - 45), Miller et al. (1993) concluded that there is a strong linkage between victimization and the development of adult alcohol problems.

One of the most important differences between men and women is that they identify different reasons for using drugs or alcohol. Women typically see drugs/alcohol use as a method of coping with specific crises or personal problems. This perception determines their definition of "problem," identification of needs and their approach to seeking help.

6. General Barriers To Treatment

6.1 Introduction

Barriers are those factors which impede entry into treatment or impede treatment continuation (Smith, 1992:8). It is recognized in the literature that although women more readily seek help for health and social problems than men, they are less likely to approach *specialized* treatment programs, at least initially (Thom, 1986; Schober and Annis, 1996). The following sections describe barriers associated with access to specialized substance abuse treatment services.

6.2 General Barriers to Treatment: Key Expert Perspectives

Key experts identified barriers to treatment in four main areas:

- personal barriers-related to a woman's personal attitudes or situations;
- interpersonal barriers-related to family or peer relationships and attitudes;
- societal barriers-related to broader community/societal attitudes or barriers;
- program/structural barriers related to program organization or structure.

6.2.1 Personal Barriers

Key experts identified four main personal barriers impeding access to treatment:

- **Shame and guilt.** Key experts noted that there is a high level of shame and guilt experienced by women who acknowledge problems with alcohol and other drugs. This shame is associated with society's rigid role definition of "a good mother" and

historical attitudes toward women who drink. Many women incorporate these attitudes and feel shame for not meeting what they perceive to be society's expectations.

- **Problems acknowledging the impact of use.** Women may have difficulties acknowledging problems with alcohol and other drugs. Sometimes they do not recognize the severity or impact of their substance misuse; there may also exist a certain stereotype of alcohol problems which is rejected as *not* being applicable.

- **Fear of losing love and support or of being isolated.** Key experts indicated that many women fear acknowledging substance use problems and attempting treatment because they fear isolation, loss of love, support and security. These fears are exacerbated by the dependence many women experience within relationships.

> *Being emotionally dependent . . . they fear the loss of the relationship – they're terrified to be alone.*

- **Being overwhelmed by other personal issues and problems.** For a significant number of women with alcohol/drug problems, addressing these problems is not a priority when considered in relation to other personal problems such as substandard housing, spousal violence or general impoverishment.

6.2.2 Interpersonal Barriers

There was a significant level of key expert consensus around two interpersonal barriers affecting access to treatment.

- **Fear of losing children.** Most key experts identified women's fears of losing their children to their partners or child welfare as a central reason for not accessing treatment. Key experts described this fear as "immense." Many women have total responsibility for their children. They fear having to give their children to child welfare (in order to enter residential treatment) and "never getting them back."

> *These women have no recourse but to depend on Health and Social Services and have their kids put in care – the fear of having kids apprehended and having their "history" tainted after having their kids in care.*

- **Lack of family support.** A lack of support from a husband, partner or family is another barrier for women needing treatment. The lack of support may be based on the family's denial or shame or on an abusive relationship which supports dependency.

> *Partners are sometimes abusive and women often get into drugs with a male partner and the male is still using and may not want her to get treatment.*

6.2.3 Community/Social Barriers

Key experts also believe that women are more seriously penalized by society (e.g. threatened with loss of children) for seeking treatment.

- **Social stigma.** Key experts believe that, in general, society views women who misuse substances more harshly than men. This makes the open acknowledgement of problems and needs difficult.

6.2.4 Structural/Program Barriers

Key experts described a wide range of structural/program barriers related to treatment availability, organization and flexibility.

- **Lack of reliable and low cost child care.** According to respondents, women worry about finding appropriate and inexpensive child care while they are in treatment. "What do I do with my kids?" is a primary consideration for women contemplating treatment.

- **Costs associated with treatment.** For some women, there are direct (partial fees) or associated (child care, transportation, wage loss) costs which make involvement in treatment difficult.* The geographical isolation of some women increases the burden of these costs. There is also typically no way to compensate for the wages of working women (who may be the sole support parent) while they are in treatment.

While some programs may provide adjunctive services (e.g. child care) at minimal or no cost, many lack the funding to provide these services.

> *There's a lack of funding for treatment centres and a lack of funding for those agencies providing transport, child care and in-house infant centres.*

Along with child care, transportation costs were highlighted as significant barriers.

- **Lack of appropriate treatment services for women.** There was a strong consensus of opinion among key experts that a fundamental barrier for women is the overall *lack* of treatment services available to women who require or request them. Canadian key experts cited the lack of the following types of services:

  - women-centred, gender-specific services (or treatment with clearly defined components for women);
  - services which are safe and provide protection from harassment and fear;

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* Treatment cost may vary jurisdiction to jurisdiction. In some provinces there are no costs for treatment services.

- services which are widely distributed and geographically accessible;
- services which are cost free.

- **A lack of flexible services.** There was also a strong degree of consensus among key experts that treatment services often lack flexibility and are not able to meet the real needs of women. Treatment should:
  - have flexible entry criteria and not insist on complete abstinence at intake;

    Policies that dictate amount of time a woman must be clean before (she) can access program/have to cure self before allowed into treatment (do not support treatment access).

  - offer flexible scheduling (alternative treatment schedules, 24-hour intake, short-term programming) which respects the personal and working needs of women and their families;

    Women are usually offered day-time programs, perhaps they need evening programs.

  - be immediately responsive to women when they have identified a need or willingness to participate in treatment.

- **Insufficient and inaccessible program information.** Respondents noted that women are often unaware of the treatment options that exist, or of what is included in treatment. This lack of awareness is more common within sub-group populations (e.g. ethno-cultural minority or isolated and rural women). Programs lack effective outreach and publicity strategies to overcome these barriers (see Section 7.0 Client Outreach, Contact and Engagement).

Table 4: General Barriers to Women's Treatment: Key Expert Perspectives

Personal Barriers	Interpersonal	Societal	Program/Structural
• Shame and guilt • Denial of problem • Fear of losing love, support and security • Fear of being isolated • Being overwhelmed by other personal issues (housing, violence) so that treatment is not a priority	• Fear of losing children to partner or child welfare • Lack of low-cost, reliable child care • Lack of family support (denial, resistance to treatment)	• Stigma attached to women who misuse substances • Stigma attached to women who seek treatment	• Cost of treatment • Costs associated with treatment (especially child care and transportation) • Lack of women centred services • Lack of flexible services (time, duration, criteria for entry) • Lack of a program, information or strategies to effectively outreach to and inform women about treatment

6.3 Barriers Experienced by Specific Groups: Key Expert Perspectives

6.3.1 Pregnant and Parenting Women

Key experts identified the following barriers as specific to pregnant and parenting women.

- **Fear of losing children.** The possibility of losing children, of having to put children in foster care or of having a record with Health or Social Services which could jeopardize the family in the future were noted as the primary barriers for this group.
- **Lack of specialized child care services.** Women who are parents may need child care services in order to participate in treatment.
- **Lack of specialized support or treatment services for children.** Children also may require specialized treatment services which address the impacts of parental substance misuse.

  > *Older kids (7 - 8) are parenting themselves at such a young age – they need help to learn how to be children again.*

- **Stigma attached to mothers misusing substances.** Mothers who misuse substances are judged more harshly than other women. Although this is a general attitude, it is also manifested by some others in the treatment field (e.g. some treatment staff and allied professionals).
- **Internal feelings of fear, guilt, grief and shame.** Although key experts noted that all women have shame and guilt around substance use, these feelings are intensified in women who are pregnant and who are concerned about the harm they may have brought to the fetus or to their children. This fear and guilt may result in difficulty acknowledging a substance use problem or in avoidance of treatment.
- **Lack of specific programming for pregnant women.** Key experts noted that pregnant women have specific programming needs which cannot be met in traditional women's programs. They typically require:
  - priority admission;
  - attention to medical problems which may result from pregnancy;
  - information and education around prenatal health, child birth and postpartum care;
  - information and services related to fetal alcohol syndrome/fetal alcohol effects (FAS/FAE).

6.3.2 Aboriginal Women

Key experts identified the following barriers as specific to Aboriginal women.

- **Cultural barriers and lack of Aboriginal specific programming.** Aboriginal women have specific ways of interpreting life and change that are often not understood or incorporated by mainstream programs. These typically include attention to spiritual

values and participation in traditional ceremonies such as healing circles or sweat lodges. Aboriginal women may also be more comfortable with oral traditions and value contact with elders. As well as not being culturally appropriate, most programs lack Aboriginal staff.

- **Lack of gender-specific programming.** According to key experts, gender-specific programming is particularly important for Aboriginal women. Gender-specific programming is seen to provide more safety, freedom from harassment and the opportunity to explore past relationships more openly.

- **Lack of community support and modelling.** Aboriginal women may come from communities where there is a lack of support for recovery or where their own efforts in recovery go unrecognized. The use of positive Aboriginal role models needs to be enhanced.

Several key experts noted that the political structure of some Aboriginal communities is male dominated. This context may result in women's issues being minimized or discourage women from speaking out about their problems.

6.3.3 Ethno-cultural Minority Women

Key experts identified four main barriers affecting ethno-cultural minority women. These are:

- **Cultural structures, beliefs or values which discourage acknowledgement of alcohol and drug problems or seeking formal treatment.** Women may live in cultural environments that do not acknowledge the existence of women's drinking or drug use. Prohibitions against substance misuse among women may be so strong that women are afraid to acknowledge problems with substance use.

  > *There are cultural taboos about women using alcohol and drugs. A woman came in for treatment and she said that she could not tell her family or cultural community that she had a drinking problem as drinking itself was unacceptable.*

  In societies where men are the head of the household, women may fear the implications of speaking out. Other women may support this pattern of denial.

  > *We're dealing with cultural aspects with families that restrict them getting into treatment. In some cultures, spouses and mothers-in-law don't allow this.*

  In some cultures, it is expected that internal, informal methods will be used to address problems.

- **Language barriers.** Language barriers significantly affect access to treatment. Programs typically lack ethno-cultural minority staff and translation is both costly and difficult to arrange.

- **Lack of culturally specific programming.** Key experts described an overall lack of treatment programming specifically designed for minority women which addresses language and cultural barriers. Programs which do exist are not culturally responsive due to a lack of ethno-cultural minority staffing, inability to address language issues or incorporate cultural content.

- **Lack of effective, culturally appropriate outreach.** Key experts noted that ethno-cultural minority women tend to be isolated and not be in touch with "mainstream" health treatment or social service agencies. Outreach needs to focus on developing connections to organizations that support minorities in order to increase accessibility.

6.3.4 Women Who Inject Drugs

Three major barriers to treatment were identified by key experts.

- **High degree of stigmatization by society, other clients and staff.** Key experts noted women who inject drugs are highly stigmatized within the drug culture. They are perceived as the "lowest" in the drug-using hierarchy by other drug users because of their lifestyles and involvement in other risk-taking behaviours (e.g. prostitution).

  Women who inject drugs experience these negative attitudes as judgmental and discriminatory. Perceived attitudes of staff and other clients may be a disincentive to treatment involvement.

- **Occurrence of serious and/or multiple health problems.** Many people who inject drugs have serious long-term problems such as HIV/hepatitis, which the staff may not be able to address within traditional treatment settings. Staff also may not have the training to deal with the serious medical or social problems presented by this group.

- **Lack of appropriate treatment to meet specialized needs.** Key experts noted that there is a lack of creative and relevant treatment programs available to women who inject drugs. Treatment approaches which would be more relevant to this group include:
  - a harm reduction rather than abstinence approach, particularly at the treatment intake stage;
  - greater availability of methadone maintenance;
  - longer and more appropriate withdrawal management services (particularly stressed as being required in remote and/or northern communities);
  - specialized treatment resources for sex trade workers.

6.3.5 Women Living with HIV/AIDS and Hepatitis C

Women with HIV/AIDS face barriers to treatment related to the isolation and stigma connected to their disease. Key experts described the most significant barriers for this group as:

- **Fear of acknowledging the disease to treatment providers or to others in treatment.** Clients with AIDS are not certain how they will be accepted in treatment. Although most staff are well informed, some may fear clients with HIV/AIDS or lack understanding of the disease. Those with HIV/AIDS also fear acknowledging the disease to other clients who may ostracize them.

  > *There's a whole stigma attached – they can't be open, yet program says that they have to be open.*

- **Isolation.** Respondents described women with HIV/AIDS as being isolated and lacking in support. They are often homeless, find it difficult to connect with other women and lack support systems and community resources that can address their needs.

  > *The social services for these women are almost non-existent.*

- **Hopelessness.** Respondents noted that a sense of hopelessness is a barrier to active treatment involvement of this group. The overall outlook and values of these clients are quite different ("Why care when you are dying anyway?"). An abstinence-based philosophy may be the *least* appropriate for this group.

6.3.6 Women with Concurrent Substance Use and Mental Health Disorders

Key experts identified many barriers affecting women with concurrent disorders. There was consensus around the following issues:

- **Inadequate diagnostic services/poor or incomplete diagnoses.** A large number of key experts noted that women with mental health disorders are poorly diagnosed at intake by both the mental health and alcohol/drug treatment systems. Substance abuse programs may not have the staff expertise to provide comprehensive mental health assessments. Mental health staff may overlook addictions problems.

  > *A woman comes in (to a mental health service) with acute depression and anxiety and is suicidal – often the dependency is overlooked.*
  >
  > ***
  >
  > *There is a lack of training in psychiatry for alcohol and drug counsellors. Interplay between mental health and alcohol and drug abuse is not understood by counsellors. They think that if alcohol and drugs are eliminated, then mental health issues will go away.*

- **Lack of coordination and integration between mental health and addictions services.** Key experts noted that there is a lack of coordination between the mental health and addictions systems which affects client access to treatment. This is characterized by:
  - a lack of staff in both systems who are trained to recognize and assess both problems;
  - a lack of system "agreement" on which problem or issue needs to be treated first;
  - a lack of ability of addictions programs to clinically manage or support women who may be taking medication;
  - a lack of coordination between systems which leads to clients being bounced back and forth between systems.

- **Isolation.** Women with concurrent problems are highly isolated. They often lack personal and family support and may fear entering treatment which involves outreach to others.

> *There's the belief they don't fit in – isolation, hopelessness and helplessness.*

6.3.7 Women in Prison or Involved with the Criminal Justice System

Respondents identified four barriers affecting women in the prison system.

- **Lack of services within the prison system.** It was the perception of key experts that women who are incarcerated have limited access to treatment services in prison settings.* Where treatment services do exist, they may not specifically be designed to meet the needs of women.

- **Restricted accessibility.** Key experts noted that women may be restricted from accessing programs, both from the criminal justice system and community program side. The criminal justice system may make access to treatment difficult for clients while they are involved with the legal system. Parole or probation staff may not refer to community-based treatment resources because of workload problems. Treatment programs themselves may restrict entry to women until their prison term is completed.

> *Many agencies insist that prison terms be finished before (a woman's) treatment starts, (the pattern) should be reversed, (programs) need to go into the prisons.*

* Alcohol/drug treatment is provided within the federal correctional system.

- **Inability of clients to use treatment effectively.** Key experts noted that women from prison settings have more difficulty becoming involved in treatment because of adjustment issues faced in the community. They may have unrealistic expectations of recovery or difficulties handling treatment expectations (they may be lacking in self-discipline or be unable to set or follow through on goals).

- **Lack of continuity between programming within the prison setting and those in the community.** Key experts noted that there may be a lack of continuity between programming within the prison setting and programming in the community.

- **Lack of trust in treatment staff and setting.** Some key experts noted that women who have been involved in the criminal justice system have difficulty trusting the treatment environment which requires openness and disclosure. Programs (both correctional or within community-based settings) may be perceived as being part of a punitive system. As a result, treatment compliance may be poor.

6.3.8 Marginalized/Homeless Women

Women who are marginalized or homeless face a range of barriers affecting treatment.

- **Poverty, lack of housing and need for other basic life supports.** Poverty and lack of housing are major impediments to treatment. Women who are struggling to meet basic needs do not search out treatment. A lack of money for transportation, food and telephone all contribute to isolation. Key experts also stressed that clients are unlikely to access treatment without safe and secure housing.

- **Lack of appropriate "gateways" to treatment.** Key experts noted that homeless women are unlikely (for reasons cited above and contributing problems such as the presence of concurrent disorders) to access traditional out-patient or residential treatment. It is difficult for them to make appointments or travel to offices of social workers or other professionals. They require the provision of immediate "upfront" resources (e.g. outreach or storefront services) and are alienated by formal, more highly structured or rigid programs.

  > *There is a lack of formal efforts to address their alcohol and drug issues without going as far as full treatment (e.g. day stabilization program where women can drop in on a daily basis). Steps are too big for them to take.*

- **Isolation.** Women who live on the street are often isolated due to poverty, lack of housing or the presence of concurrent disorders. This isolation makes contact with treatment services difficult.

  > *It's difficult to access treatment without a phone, difficult to call, difficult to follow up.*

***

Isolated – if not connected to social services, don't know what programs are available.

6.3.9 Women Living in Rural Communities

According to key experts, barriers to treatment experienced by women living in rural communities include:

- **Lack of confidentiality and privacy.** Acknowledgement of alcohol/drug problems is particularly difficult in small communities where social networks are small and interconnected, and where there is a lack of privacy and confidentiality. By acknowledging problems with alcohol or drugs, women risk not only their own reputations but those of their families and children.

  They are afraid to be identified by neighbours. They even fear picking up a pamphlet because someone will see and spread the news.

  ***

  The issue of accessing treatment in small towns is confidentiality – and if they leave their community to go to residential treatment there are still questions about where they are.

  ***

  There are confidentiality issues – some of their own family members may be employed at the treatment centres.

- **Isolation/Lack of awareness of services.** Women who live in rural or geographically remote communities are isolated and may not be aware of or able to access services.

- **A lack of transportation (or the funds to pay for transportation).** A lack of transportation to treatment is a major barrier for rural women.

- **A lack of services which are accessible, flexible and women oriented.** There are fewer treatment services of any type available to rural women. Rural women also lack services which are flexible and responsive to their needs.

  Intervention in programs are bigger than what they need because they have to go to residential centres.

  ***

  There aren't enough flexible services – most rural women would prefer out patient services and these are not available in rural areas.

To access services, women are often compelled to leave their communities and assume the costs associated with housing, transportation and child care. In many cases, adjustment to a different (urban) setting is difficult.

Table 5: Barriers Associated with Specific Groups

Group	Barriers Identified by Key Respondents
Pregnant and parenting women	➞ Fear of losing children ➞ Need for child care services ➞ Stigma attached to mothers misusing substances ➞ Fear, guilt, grief and shame ➞ Lack of specific programming for pregnancy and child birth issues
Aboriginal women	➞ Cultural differences ➞ Lack of aboriginal specific programming ➞ Lack of aboriginal staffing ➞ Lack of gender-specific programming
Ethno-cultural minority women	➞ Language barriers ➞ Denial of women's substance use ➞ Cultural beliefs and practices which support denial ➞ Reliance on informal problem-solving methods ➞ Male-dominated cultures ➞ Lack of culturally specific programming ➞ Lack of culturally appropriate and effective street outreach
Women who inject drugs	➞ Shame, judgment, discrimination ➞ Long-term health problems ➞ Lack of appropriate programs (harm reduction model, detox services, methadone maintenance) ➞ Lack of programs for sex trade workers
Women with HIV/AIDS	➞ Fear of acknowledging disease to treatment staff ➞ Stigmatized ➞ Ostracized by other clients ➞ Multiple health problems ➞ Isolation ➞ Feelings of hopelessness
Women with concurrent mental health disorders	➞ Inadequate diagnostic/assessment services ➞ Lack of coordination/integration between mental health/addictions systems ➞ Isolation
Women in prison or involved in criminal justice system	➞ Lack of prison-based services ➞ Restricted access to community-based programs ➞ Inability to use treatment effectively ➞ Lack of continuity between prison-based and community programming ➞ Trust
Marginalized/homeless women	➞ Poverty, lack of housing and other basic needs ➞ Lack of appropriate "gateways" to treatment ➞ Isolation (program's inability to maintain contact)
Women living in rural communities	➞ Isolation ➞ Lack of local services ➞ Lack of knowledge of services ➞ Lack of privacy/confidentiality ➞ High costs of accessing services (transportation, child care)

6.4 General Barriers to Treatment Access: Literature Review

Most people with alcohol/drug use problems do not enter treatment (Grant, 1997). Of those who do, the ratio of men accessing specialized treatment is much higher than for women (Schober and Annis, 1996). There is evidence in the literature that a woman's pathway to treatment is unique and her experience and interpretation of barriers complex.

There is also extensive literature which identifies barriers to treatment experienced by women with alcohol/drug use problems. Although these barriers are categorized somewhat differently, a summary of barriers applying to all women is presented below: (Beckman and Amaro, 1986; Thom, 1986; Thom, 1986, 1987; Cooper, 1991; Wilsnack, 1991; Cunningham and Sobell,1993; Ja and Aoki, 1993; Planning for Change, 1993; Saskatchewan Alcohol and Drug Abuse Commission, 1993; Allen, 1994; Beckman, 1994b; Schober and Annis, 1996; Copeland, 1997; Finkelstein et al., 1997; Grant, 1997; Klein et al., 1997).

The barriers described in the literature broadly reflect the themes identified by key experts, although the literature emphasizes to a greater degree barriers related to "gateways" or entry points into treatment.

6.4.1 Personal Barriers

The literature identifies the following personal/internal barriers which affect women's access to treatment.

- **Shame and embarrassment related to social stigma and labelling.** Society stigmatizes those who misuse alcohol and drugs (Beckman and Amaro, 1986; Copeland, 1997). This stigma is magnified for women. Drinking may be associated with "moral laxity or maternal deficiencies." Stigma and shame may also contribute to the difficulty women experience in defining themselves as having alcohol use problems (Smith, 1992).

- **Lack of confidence in alcohol treatment and its effectiveness.** Even when adults see the need for alcohol treatment, many do not access it. In a study of males and females with alcohol use problems, Grant (1997) found that a major reason for not accessing treatment was a lack of confidence in the alcohol treatment system and its effectiveness.

- **A belief that people who use substances should be able to handle impacts and problems themselves.** Grant (1997), in a study of men and women with alcohol use disorders, found that 30% of 964 subjects with alcohol use disorders did not consider entering treatment because they believed they should be "strong enough to help themselves." Twenty percent believed their drinking problem would get better by itself; 23% thought the problem was not serious enough to warrant help.

Thom (1987), in a study of gender differences in seeking treatment for alcohol problems, found that women did not regard alcohol as a primary problem and had considerable reservations about the relevance of treatment to their needs.

- **Lack of information about treatment programs and resources.** In an analysis of barriers to treatment, Allen (1994) identified lack of awareness of treatment programs as a major barrier for women. Grant noted that women are more likely to say they don't know where to go for help (than men).

If women are more likely to rely on referrals by family or friends or learn about the treatment programs through advertisements or word of mouth, then the results of this study suggest a need to expand the more conventional referral routes for women (Grant, 1997: 370).

- **Experience of violence and abuse/need for safety.** Copeland and Hall (1992) in a study of 160 women in treatment, noted that 86% experienced physical or sexual abuse at some time in their lives. Women who have experienced violence in their lives may have more stringent needs for a safe and secure environment which they worry cannot be met in treatment.

- **Ways of viewing alcohol/drug problem/gateways into treatment.** In general, women see alcohol/drug use as a response to social, mental health or health needs or issues. Women are less likely than men to perceive their drinking as source of difficulties (legal, financial, family or work-related) in their lives. Instead, they identify anxiety, depression and stressful events as contributors. Gomberg (as cited in Beckman, 1994b) reported that the most frequent reasons given by women for seeking treatment are depression, medical problems, problems with family relationships and feelings related to children leaving the home.

Because of these differences, women are less likely than men to initially seek help from alcohol or other chemical dependency services. Instead, women are more likely to consult their physician or mental health services when they have problems. Substance use problems may not be appropriately identified.

6.4.2 Interpersonal Barriers

Beckman and Amaro (1986) noted that women perceive greater social costs associated with entering alcohol treatment. Almost 50% (versus 20% of men) described problems with family, friends or money as disincentives to entering treatment.

Women also encounter more opposition from family and friends during the months prior to treatment entry. Studies also found that women are often encouraged to keep on drinking by spouses or partners who themselves have alcohol use problems (Wilsnack, 1991).

6.4.3 Structural and Program Barriers

Structural and program barriers also act as disincentives to women entering treatment. These barriers include:

- **Limited program outreach.** Swift and Copeland noted that treatment services often lack outreach or referral mechanisms which assist women to enter treatment.

> (Program) responses could include improved outreach, referral networks or advertising of services specifically targeting women who may be unaware of the range of services. The provision of more detailed information about programs may allay any fears potential clients, their partners and/or families may have about what treatment involves. (Swift and Copeland, 1996:217)

- **Inadequate referral systems.** Women are not regularly referred from the generic mental health programs they initially access or from their personal physicians for a range of reasons, including the inability of professionals to screen for treatment and women's unwillingness to acknowledge problems associated with substance use (Mulford as cited in Smith, 1992).

- **Costs associated with treatment.** Women requiring treatment often have low incomes and limited economic resources. Direct costs of treatment, replacement of wages and treatment support costs (child care, transportation) may make treatment inaccessible to women (Beckman and Amaro, 1986).

- **Treatment structured on basis of male treatment.** The literature suggests that alcohol/drug treatment has commonly been structured to meet the needs of men rather than women (Wilke, 1994). This "male as norm bias" is manifested by a lack of woman-specific program elements, limited female staffing and restricted attention to women's values and ways of interacting. For example, Smith noted that women may be more responsive than men to multi-model programs which include support groups, attention to sexual abuse and spousal violence issues.

> Traditional treatment programs tend to reflect traditional male values such as the importance of the male work ethos and the need for men to be in full-time employment. This may be communicated covertly through the organization of programs on a day-to-day basis . . . . (Smith, 1992:8)

- **Attitudes of service providers.** Vanicelli (as cited in Smith, 1992) noted that health care providers may share the same negative values toward women with substance use problems as the public at large, in particular, the belief that women with addiction problems have a poorer prognosis and are more difficult to treat.

- **Misdiagnosis, lack of effective referral networks.** General practitioners often misdiagnose patients with alcohol/drug problems. If alcohol/drug problems are *not* clearly identified in the initial stages of intake, women are unlikely to be referred to specialized treatment services. In a study of caseload practice, Mulford (as cited in Smith, 1992) found that only 10% of women (requiring treatment) had been referred to treatment by their doctors; instead, nearly 50% had been prescribed medication for nerves or menopause.

There is also an increased incidence of depression, anxiety and post traumatic stress disorders among women with alcohol use problems. The presence of these disorders means that women are more likely to seek help at general mental health centres which may not be a direct pathway to treatment (Schober and Annis, 1996). Even with identification and referral, women may be less willing to identify their problems as substance abuse related.

- **Lack of child care services and resources.** The lack of child care services or resources to pay for children services are primary reasons why women do not access treatment services. Women may also fear losing their children to welfare authorities. In a survey of respondents who provide treatment, Wilsnack (1991) identified responsibility for dependent children as one of the primary barriers for women. Women are more likely than men to utilize alcohol treatment agencies that provide child care and/or treatment for children (Beckman and Kocel as cited in Schober and Annis, 1996).

Other structural/program barriers identified in the literature include:

- lack of women on staff (Allen, 1994; Beckman and Kasl as cited in Schober and Annis, 1996);
- rigid abstinence requirements (which are too inflexible for most women);
- failure to provide consistent staffing (Schober and Annis, 1996);
- placement of settings (in stigmatizing psychiatric settings) (Schober and Annis, 1996);
- low morale and commitment of staff (Schober and Annis, 1996);
- wait lists (Schober and Annis, 1996).

6.5 Barriers of Specific Groups: Literature Review

The literature does not address, in detail, barriers experienced by all the sub-groups identified in this study. However, a summary of available literature related to some of these groups is presented below.

6.5.1 Pregnant and Parenting Women

Finkelstein (1994), in a study of treatment needs of pregnant women, identified two major barriers experienced by this group.

- **Negative attitudes which stigmatize, reject and blame women.** Pregnant and parenting women are more heavily stigmatized by society. Rejection and blame are commonly expressed by community and health and social service personnel.
- **A lack of treatment and related resources specifically geared to pregnant and parenting women.** Finkelstein noted that there is a lack of treatment facilities which:
  - can handle medical issues (such as appropriate detoxification) during pregnancy;
  - can address perinatal issues;

- can provide infant care or care to other children while the mother is in treatment;
- address cost factors;
- provide adequate training to staff.

In a study of 47 women (40% of whom were Aboriginal) who had problems with alcohol or other drugs and who were pregnant or parenting (children under the age of 16) in Vancouver and Prince George, British Columbia, Poole and Issac (1999) described seven main barriers identified by respondents. These included both personal and structural barriers:

- shame (66%);
- fear of losing children if women identified themselves as needing treatment (62%);
- fear of prejudicial treatment on the basis of motherhood/pregnancy status (60%);
- feelings of depression and low self-esteem (50%);
- belief women could handle the problem without treatment (55%);
- lack of information as to what was available (55%);
- waiting lists for treatment services (53%).

6.5.2 Women with Concurrent Substance Use and Mental Health Disorders

- **Fragmentation of treatment system.** Grella (1996) noted that differences in the philosophy or approaches of the mental health and substance abuse treatment systems often create additional barriers for women with concurrent mental health disorders. Differences exist in the following areas:
  - the definition and interpretation of the problem;
  - the interpretation of client motivation and determination of client "readiness" for treatment;
  - accepted methods of treatment and treatment modalities;
  - staff attitudes toward using drugs as treatment support;
  - treatment duration;
  - staff characteristics, skills and training.

These differences result in the lack of a coordinated approach, inadequate diagnoses and inconsistencies in treatment provision.

6.5.3 Aboriginal Women

There is a lack of specific data that identifies barriers experienced by Aboriginal women. Results from a Canadian national conference on women and chemical dependencies (Planning for Change, 1993) concluded that the following barriers were most significant for this group:

- wait lists;
- lack of child care services;
- language barriers/lack of translation services;
- poor referral networks;
- family responsibilities not addressed;
- stigma;
- lack of family support.

6.5.4 Ethno-cultural Minority Women

A Health Canada study of immigrant women and substance use (Health Canada,1996a) identified a number of issues related to service access and barriers for an immigrant woman experiencing a substance use problem. These included lack of expertise and resources on the part of both mainstream health organizations and immigrant aid or ethno-cultural organizations to address women's substance use problems; lack of information or misinformation about availability of culturally appropriate services, which often resulted in inappropriate referrals or women being referred back and forth between a mainstream health organization and an ethno-cultural organization; unrealistic expectations by mainstream organizations about the ability and resources of ethno-cultural/immigrant aid organizations to provide substance abuse treatment.

As a result of these barriers, the report noted that immigrant women with substance use problems may receive no help or information, or if they do it may be in an unfamiliar language or in their own language but from people who are inexperienced in the area of substance use problems, or from a perspective that does not take into account their cultural reality and/or their needs as women.

Ja and Aoki (1993), in a study of barriers to treatment for Asian-American* women identified some additional barriers:

- **Lack of substance use prevalence data.** Asians have been stereotyped as a "model minority" with the generally accepted view that they use substances at a lower rate than others. For this reason, many statistical surveys exclude them and other ethno-cultural minority groups. However, evidence suggests that there are diverse rates of use among different Asian sub-groups (Chi as cited in Ja and Aoki, 1993).
- **Cultural expectations or values.** Because of cultural beliefs or practices, families or ethnic communities may ignore, deny or dismiss alcohol or drug problems or discourage women from seeking treatment in the outside community.

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* These conclusions may not apply to other ethnno-cultural minority groups.

- **A lack of culturally sensitive programs.** The authors concluded that simply adapting mainstream programs to ethnic minorities may not be adequate to serve the needs of women. Programs need components that speak directly to ethnic practices and values. Additional components include a strong focus on program orientation (clearly describing program goals), content and expected outcomes, incorporation of non-confrontational approaches, family counselling and creative elements (art, music, dance or theatre).
- **Lack of specialized addiction treatment programs.** Treatment in ethno-cultural minority communities is often provided by generic, unspecialized and unqualified agencies.
- **Poor/confused motivation within client group** related to shame and family denial.
- **A lack of programs which respect or build on the family unit.**
- **Inadequate/untrained referral sources to facilitate referrals to treatment.**
- **Reliance on informal family problem-solving mechanisms.**

6.5.5 Women Living in Rural Communities

A Health Canada study: *Rural Women and Substance Use: Issues and Implications for Programming* (Health Canada, 1996b), identified a number of program and service issues, including:

- **Lack of appropriate services for women.** This may include lack of the service itself or understaffed or under-supplied services, providing a limited range of referral options.
- **Lack of women-centred services.** In rural areas, assessment and treatment services may reflect a traditional or male model of intervention; also, existing services may have a single approach (e.g. abstinence), and not provide harm reduction services.
- **Inadequate counselling for sexual and physical abuse.** In particular, lack of treatment for women abused as children is a major problem.
- **Professionals lack of knowledge about the reality of rural women's lives.** "People with problems want to talk to their peers" (Health Canada, 1996c). Rural women with substance use problems may have difficulty finding a helping person who is familiar with rural life and its problems.

Additional barriers identified in a study of illegal drug use among rural adults (Robertson and Donnermeyer, 1997) included distance and lack of transportation as major barriers to treatment utilization. The chronic poverty conditions within many rural areas makes access by clients to early intervention difficult. Costs associated with treatment are also a disincentive (e.g. transportation, payment for board and lodging in residential programs).

6.5.6 Women in Prison

A general lack of treatment or related programs for women within correctional settings was described as the major barrier for this sub-group.

In Canada, 56% of the female prison population is estimated to have been involved in drug-related crimes (Lightfoot and Lambert as cited in Lightfoot et al., 1996b). At the federal level, Correctional Service of Canada provides treatment both at the institutional and community level. However, no specific information was available on the extent, scope and content of treatment for women in provincial correctional settings.

A recent publication, *Substance Abuse Treatment for Women Offenders: Guide to Promising Practices,* from the U.S. Substance Abuse and Mental Health Services Administration (SAMHSA), (1999), summarizes the research on women offenders with substance abuse problems and provides guidelines for women-centred treatment in a correctional setting, including the system issues and barriers that need to be addressed. This publication is available on-line as well as in hard copy from SAMHSA.

6.5.7 Street Involved Homeless Women

No specific data related to barriers experienced by women who are street involved or homeless were found in the literature. Milby et al., in a study of both male and female homeless substance abusers, suggested that the state of homelessness fundamentally compromises a person's ability to respond favourably to treatment.

> Perhaps the need for some rest and sleep, food and shelter from weather are prepotent over the need for treatment of a substance abuse problem. (Milby et al., 1996:40)

This study showed that day treatment plus work therapy and housing support led to improved treatment outcomes. The provision of a *multi-dimensional* support system appears to be most critical for dismantling barriers to this group.

7. Client Outreach, Contact and Engagement*

7.1 Client Outreach, Contact and Engagement: Key Expert Perspectives

The literature suggests that women typically do not contact specialized treatment services directly but are referred through mental health, social services, health organizations or their own physicians. This appears to be due to factors such as shame, stigma and denial or the way substance misuse is defined. Key experts identified a number of best practices to support women's early engagement in treatment.

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* In this section and those that follow, tables of effective programming elements are not in order of importance.

- **The development of a multi-dimensional publicity/outreach strategy which is informative, accessible and non-stigmatizing.** There was a strong degree of key expert consensus that outreach strategies needed to be carefully formulated to address women's needs and fears. The elements of an effective treatment publicity strategy are described below.

Table 6: Elements of an Effective Program Publicity Strategy

Elements
• Distribute publicity/program information materials to locations where women congregate or visit (laundromats, playgrounds, doctors' offices, parent drop-ins, cosmetic and clothing departments, drug stores, well baby centres).
• Emphasize the confidentiality and safety of treatment and privacy of clients in program publicity.
• Emphasize the range of treatment options available (type, duration, time, format) in publicity.
• Make the tone of publicity positive, hopeful and non-judgmental.
• Distribute publicity in a variety of formats (pamphlets, posters and public service announcements).
• Provide a toll-free information line for basic education and information, including addressing concerns such as lack of confidence in treatment effectiveness or beliefs that people should be able to handle their own problems.
• Make sure that publicity speaks to the needs of the mother, not just the unborn child.
• Emphasize action, practical help and immediate response in publicity.

As noted by one key expert, program publicity should provide women with a sense of empowerment.

> *Don't say "you have a problem" but very specifically address the behaviour and say "here is what you can do about it." Give women some control, some helpful information.*

- **The building of a collaborative approach with physicians which would strengthen referrals.** Physicians are typically a first point of contact for women experiencing health or mental health problems. However, physicians make comparatively few referrals to specialized treatment programs.

> *Health care workers need to "end the conspiracy of silence" after these women go to see their physicians, and the physicians need to screen for dependencies.*

- **The creation of strong linkages with other community organizations serving women.** Linkages could include training and support of treatment-related staff, exchange of information (about client needs and characteristics or program resources) or placement of workers in other organizations.

> *Through prevention done in the schools, kids bring home an invitation to parents inviting them to workshops.*
>
> ***
>
> *Teen women are at high risk of getting into drugs and prostitution so having a Youth Worker at the friendship centre is really beneficial.*
>
> ***
>
> *Provide some consultations to these workers: Street workers, van workers, mental health workers.*

- **Direct outreach to sites where potential clients live or work.** The physical presence of workers on the street is particularly important for Aboriginal, street involved or ethno-cultural minority women.

> *Go right into their homes – in a community is easy – do a survey (door to door) with help in community (to provide publicity).*
>
> ***
>
> *Aboriginal women – going into their site (cultural centre) is very important – they see providers' interests that way.*
>
> ***
>
> *Go into the jails and hospitals to see them.*

- **Provision of a menu of treatment and treatment-related services.** Key experts stressed the importance of providing a menu of options which women can assess and select according to their needs.

> *Have flexible options (in-patient, day treatment out-patient) and let women choose the option, based on what her life is like.*

Options should be based on a range of choices not solely related to treatment.

> *Give them what they are asking for when they need it – really listen to what she's asking for and give it to her in the order she asks.*

- **The provision of treatment which has flexible and open entry criteria (non-abstinence related).** Abstinence should not be a requirement at the treatment contact stage. An acceptance of the woman's current situation, an understanding of relapse and a focus on harm reduction are more appropriate at the treatment engagement stage.
- **The provision of women-centred, culturally appropriate treatment.** There was strong consensus around the need for women-centred programming which addresses women's situations, needs and values. Treatment should also respect cultural and language differences and incorporate culturally responsive elements.
- **The provision of realistic and realizable treatment information.** Initial treatment information and expectations must not overwhelm women. Treatment goals should be realistic and plans to achieve them realizable.
- **The need for an "empowerment" approach to treatment.** Key experts identified an "empowerment" approach as the most effective way of attracting women to and engaging them in treatment. The elements of this empowerment model (as described by respondents) include:
  - giving women the opportunity to define their own needs;
  - respecting women's choices;
  - helping women access the range of treatment options they require;
  - using a Stages of Change model to explore where women are at and where they want to go;
  - staff trusting in the ability of women to make positive life decisions;
  - helping women to reframe their experiences in a non-judgmental way.

> *Conceptualize behaviour rather than label it – have women understand their using in terms of how they cope with their lives – validate their experiences, their addiction as a coping mechanism rather than shaming them.*

- **Provision of timely and (structurally) accessible treatment.** Key experts also stressed the importance of providing easily accessible and timely services through:
  - the provision of practical supports which help them access treatment (bus, transport costs);
  - user-friendly treatment structures (e.g. one-stop shopping for treatment services).

Table 7: Client, Outreach, Contact and Engagement

Best Practice Elements: Client Outreach, Contact and Engagement
• Develop a publicity system which is multi-dimensional, informative, non-stigmatizing accessible and solution oriented.
• Locate publicity in non-traditional venues.
• Stress confidentiality of services in publicity.
• Present publicity in a variety of formats.
• Collaborate with physicians and health care workers to promote more and better referrals.
• Establish strong linkages with other organizations serving women.
• Provide direct outreach on site where feasible (may be particularly relevant to Aboriginal women living in isolated communities).
• Provide a menu of services not all directly treatment related.
• Use harm reduction not abstinence as an engagement approach.
• Offer culturally appropriate treatment.
• Offer women-centred treatment.
• Use empowerment model to attract women.
• Present treatment realistically.
• Provide easy access to treatment (e.g. one stop shopping, flexible hours, convenient locations).
• Provide resources (e.g. for transportation) which assist client to engage in treatment.

7.2 Treatment Outreach, Contact and Engagement: Literature Review

The literature on treatment contact and engagement is integrated with the literature identifying barriers and optimal treatment approaches. An extrapolation of this literature identifies the following best practices in the area of treatment outreach and engagement.

- **The importance of active assistance with treatment referral and entry.** Booth et al. (1992), in a study of treatment entry of males and females who inject opiates, found that the active assistance of staff at treatment entry (scheduling intakes, assistance with providing transportation and waiving admission fees) was more closely associated with treatment entry than a less proactive approach (although overall rates of treatment retention for this group were low).
- **The importance of active contact with community outreach workers.** Booth et al. (1992) also concluded that clients who had had contact with community outreach workers were more likely to have entered treatment than others.

- **Use of high-intensity referrals.** Loneck et al. (1997) found that "high-intensity referrals" are more effective than "low-intensity" referrals at engaging and retaining women in treatment. A high-intensity referral is a therapeutic technique where members of a woman's social network use an intensive approach to discuss the impacts of drinking. Members of the network are trained and impacts are expressed with care and concern. This approach strengthens client motivation in a non-judgmental way.

  The authors note that some high-intensity techniques can be coercive. Appropriate safeguards must be put in place to ensure that these techniques do not perpetrate oppressive relationships.

- **Education of and liaison with key referral sources.** Thom (1986), Smith (1992) and Allen (1994) noted that women's pathways to treatment differ from those of men in several ways.

Women tend to seek help at non-specialized services for general and specific reasons. They are more positive about health and social services. In general, women:

> Use the services of mental health hospitals, community mental health centres, general hospital in-patient and out-patient psychiatric facilities more than men do. (Russo and Sobel as cited in Smith, 1992:4)

> They are also less likely than men to seek help initially at specialized agencies. "Instead women prefer consulting physicians or mental health clinic staff . . . (where) their problem is less likely to be diagnosed as alcohol abuse." (Beckman, 1994b:208)

There are also differences in treatment engagement within different classes of women.

> Female alcoholics used services in ways similar in *(sic)* other groups in terms of socio-economic status; that is, middle and upper class female drinkers were more likely to seek medical and psychiatric services for their alcohol problems. Women of lower socio-economic groups presenting with multiple problems turned to professional health care only when informal systems were exhausted (Marsh and Miller as cited in Smith, 1992:4).

Smith (1992) noted that general practitioners fail to detect alcohol problems or misdiagnose a substantial proportion of patients with alcohol use disorders. In a study by Thom and Tellez (as cited in Smith, 1992), doctors were asked about their approaches to patients with alcohol problems. Because doctors felt largely pessimistic about resolving the problem, they were inclined to look for other explanations for drinking problems which do not require treatment.

- **Agency characteristics.** Certain agency characteristics appear to be associated with client engagement in treatment.

Swift and Copeland (1996), in a national survey of treatment needs and experiences of 267 Australian women who had received treatment, identified the following program characteristics as important to women:

- reputation of treatment program or recommendations from someone else (23%);
- location of agency close to home (16%);
- low cost and approach of program (11%);
- women-only orientation of program or safety (6%);
- provision of child care (8%).

- **Provision of family counselling.** Women are often discouraged from taking part in treatment because of family opposition, inability to perceive drug use as problematic or because partners also misuse substances (Thom, 1987).

> The opposition of family members to treatment and, consequently, the disruption of family relationships are part of the "social costs" associated by many women with alcoholism treatment. (Beckman, 1994b:208)

Family therapy may play an important part in involving resistant family members in the treatment process (Smith, 1992). Sommers and Travis (as cited in Schliebner, 1994) noted that involvement of family and friends can support family and assist women to explore new self-concepts. However, Beckman (1994b) noted that the family support in treatment must be empowering to women.

- **Broad approach to outreach.** Finkelstein et al. (1997) identified the following broad outreach strategies as being most effective. Strategies include both a process to address barriers and appropriate deployment of staff. Outreach strategies include:
  - determining an outreach response which addresses the specific barriers women face. This would involve a detailed analysis of barriers and exploration of appropriate responses to these barriers;
  - training professional caregivers in the early identification of client problems and needs;
  - making community presentations on substance misuse and program resources;
  - employing community outreach workers.

She particularly noted the importance of assisting health care professionals to screen and refer women.

Reed (1987) also stressed the importance of a broad approach to outreach.

> Outreach should target these people who see women regularly (hairdressers), who work with their children or who have some influence with them (e.g., clergy, key family members).

Many women respond well to direct outreach efforts (e.g., TV spots, ads) (Reed, 1987:160).

- **Provision of direct resources to those who require treatment.** Provision of direct resources is also related to client engagement. Hagan et al. (1994) noted that women often experience poverty and role devaluation. In one study of admissions, it was found that the provision of housing in lower-income groups of drug-dependent women may be associated with positive engagement in treatment and assist in the initial stages of recovery.
- **Accessibility and availability of treatment.** Waltman (1995) identified several pre-conditions for effective treatment (for both men and women) related to treatment accessibility. The elements of accessibility include:
  - immediacy of treatment—treatment begins at the referral stage;
  - availability—open admission;
  - convenience—close to population, near public transportation, availability of satellite offices;
  - accommodation of needs—informal drop-ins, services offered every day of the week, 24-hour services, provision of adjunctive services;
  - acceptability—staff who can address cultural needs, strong linkage with community groups, program components which meet special needs.

- **Flexibility of treatment.** Flexible treatment services are particularly important to certain populations such as women with concurrent substance use and mental health disorders. Grella noted that:

> Individuals with co-occurring psychiatric and substance abuse disorders often follow a pattern of service utilization that has been characterized as "interrupted treatment." An ability to move in and out of treatment and ease of access to services are necessary to engaging or re-engaging women who are pregnant and parenting and who have co-occurring disorders. (Grella, 1996:329)

- **Culturally appropriate treatment.** Ja and Aoki (1993) noted that cultural adaptations within mainstream programs may not be sufficient to engage ethno-cultural minority groups in treatment. Treatment programs may need to be highly ethnic specific (to include ethno-cultural minority staff and cultural practices).

8.0 Treatment Principles and Values

8.1 Treatment Principles and Values: Key Expert Perspectives

Key experts identified 13 basic treatment principles and values which underlie the effective treatment of women with substance use problems. These principles and values address structural, organizational and philosophical elements of treatment.

Table 8: Overall Principles and Values of Treatment: Key Expert Perspectives

Treatment Principles and Values	Key Expert Quotes
Treatment for women should be based on choice (a "menu" of choices and a variety of options).	➞ Offer a variety, extensive menu.
Treatment should support a harm reduction approach.	➞ Lapsing is to be expected and can be explored. ➞ Use addiction management approach—don't have to adopt abstinence model.
Treatment should address all aspects of a woman's life.	➞ Look at the person's whole being, not just the addiction. ➞ Use a holistic approach.
Treatment should address practical needs (housing, transportation, child care and job training).	➞ Address issues around parenting ... , job training ..., provide child care.
Treatment should support connections between women.	➞ Help make connections with other women, other mothers. ➞ Empowering women to help them support each other.
Treatment should be gender specific (i.e. completely gender specific or gender-specific component of a co-ed program).	➞ Do specific women's programming. ➞ Do women-focussed, gender-specific programming.
Treatment should be supportive, egalitarian and non-hierarchical.	➞ Groups of women receiving help from female treatment providers, working and growing together in an atmosphere of equality.
Treatment should support the empowerment of women.	➞ Trust and respect women's ways of knowing and being in the world—honour clients' power with, rather than power over—women are the experts.
Treatment should be respectful and staff should empathize with and support the dignity of clients.	➞ Empathy for clients—not shaming or condescending.
Treatment should be client driven and based on individual client needs.	➞ Good treatment providers help clients achieve what they are seeking and then support. ➞ Women directed. Involving her in the planning and goals builds self-esteem, counteracts the depression.
Treatment should facilitate the education and awareness of clients.	➞ Provide literature, women need to read. ➞ Hope and information, important in early treatment.
Treatment should be based on client strengths, not deficits.	➞ Real valuing of client strengths/strength-based approach.
Treatment should incorporate a woman-centred approach.	➞ Feminist approach (e.g. awareness of women's social conditions, experience of inequality, victimization, embedded in a background of women's experiences).

8.2 Treatment Values and Philosophy: Literature Review

It was difficult to differentiate treatment principles from a discussion of issues such as treatment structure, approaches or methods in the literature. However, many of the principles identified by key experts (e.g. empowerment and harm reduction approaches) are supported by the literature review.

Finkelstein noted that most "models of care (for pregnant and parenting women) have been developed without thought given to the underlying conceptual or philosophical framework and service intent" (Finkelstein, 1993:1286). Given the concern with developing new service models for pregnant and parenting women with substance abuse problems (and their children), she suggested that "a first step in the development of such models would be to agree on certain guiding principles as a foundation" (Finkelstein, 1993:1286). She identified seven principles (see below) related to the focus and organization of treatment. Although they are discussed in relation to pregnant and parenting women, most of the principles apply to all women requiring treatment.

Principles of Treatment (Organization and Focus of Treatment)

- **Treatment should be family focussed.** This principle reflects the understanding that substance misuse affects family functioning. It also recognizes and respects cultural diversity and the importance many cultures place on the stability of the family unit. A family model works to ensuring the needs of all its members.
- **Treatment should promote competency building and empowerment.** Finkelstein described this approach as focussing on identifying and building on strengths rather than deficits and women being supported to define their own needs and priorities.
- **Treatment should be community-based.** Finkelstein noted that programs should be based in local communities and responsive to the cultural communities they serve.
- **Treatment should be multi-disciplinary, comprehensive, coordinated and work toward achieving a collaborative model.** Finkelstein identified the importance of providing a range of services (e.g. mental health, prenatal care, education and support, nutritional and vocational services). This requires the coordination of a variety of professionals.
- **Treatment should address practical, non-treatment needs.** This includes a focus on issues such as health, child care, housing and employment as well as mental health issues.
- **Treatment should be individually tailored and long-term (depending on the needs of the woman).**
- **Treatment should include different levels of service intensity and a continuum of care.**

According to Schliebner (1994), *gender sensitivity* is the most important underlying principle of treatment. Gender-sensitive treatment comprises:

- an understanding of the social, gender and economic barriers to treatment for women;
- an understanding that the physiological development of addiction is different for women than for men;
- treatment that addresses specific women's needs;

- specialized counselling skills of staff (which address issues such as sex role stereotyping);
- a focus on nurturance, empowerment, valuing of relationships and provision of an environment where women can heal;
- provision of services that support women (e.g. child care, self-development);
- a focus on supportive relationships between women.

Covington (1998a) also stressed the valuing of relationships as an underlying principle of treatment. Relational theory emphasizes the importance of relationships to women. True connections are mutual, empathic, creative, energy-releasing, empowering and essential for fostering women's growth. Effective services for women need to be based on relational theory, be gender specific, consider life experiences and incorporate a holistic theory of addictions and a theory of trauma.

Creamer and McMurtrie (1998), in a study of special needs of pregnant and parenting women in recovery, described several underlying principles/values:

- an empowerment and strength-based approach;
- a client-directed approach;
- a harm reduction model;
- comprehensiveness of care.

Key expert opinions and the literature identify the empowerment principle as fundamental to best practice. The empowerment approach is composed of the following elements (Kasl, 1995):

- based on love, not fear;
- holistic approach to problem;
- works toward transformation;
- embodies choice;
- accepts complexity;
- is flexible;
- is creative;
- does not label or judge;
- respects women's wisdom;
- involves community effort.

While many specific components of the empowerment model are associated with best practice, there is a lack of empirical research which assesses treatment outcomes based on this approach.

9.0 Treatment Approaches and Methods

9.1 Treatment Approaches and Methods: Key Expert Perspectives

Key experts were asked to identify specific substance abuse treatment approaches and methods which result in treatment success. These were discussed in relation to four broad areas.

- treatment approaches and methods to address physical health issues;
- treatment approaches and methods to address emotional health (including mental health) issues;
- treatment approaches and methods to address interpersonal issues (family and peer relationships);
- treatment approaches and methods to address relapse management/prevention.

9.1.1 Treatment Approaches to Address Physical Health Issues

Key experts identified seven elements of best practice to address physical health needs.

- **A menu of approaches and resources which are based on exploring and addressing the interrelationships between health issues and practices (e.g. exercise as a stress reduction strategy).**

  No single approach is adequate. A variety of services needs to be available.

  ***

  Give educational approach (i.e. substance abuse and eating is a triangle – make connections).

- **A strong educational component which explores the impact of substances on women's bodies.**

  High degree of education should be done through group and individual work – done with professional and non-professional staff.

- **A strong focus on nutritional education, information and support, with opportunities to practice skills.**

  Have a nutrition counsellor on site, eat in a certain way to help withdrawal symptoms – need good nutrition plan. The residents themselves are involved in food preparations (i.e. budgeting, food temperature and maintaining good eating habit).

- **Accessibility (through program referral) to a range of specialists and allied professionals who can address health-specific problems (e.g. nutrition counsellors, health promotion workers, physicians, eating disorder specialists and nurses). For women living with HIV/AIDS or hepatitis, the issue of the interaction between methadone and anti-viral medications for HIV/AIDS should also be addressed.**

  > *If treatment program does not have on-site staff trained in health issues, you need a good referral network, key is to have a good referral network.*

- **Availability of on-site medical staff (particularly in residential settings). Key experts stressed the value of having physicians, nurses or nutritional counsellors on program staff. (On-site may not be practical or affordable for most programs. The priority should be on effective linkages with medical/health specialists).**

  > *In residential setting have a house physician. Have nursing staff to test, educate, help identify problems.*

- **Specialized approach to addressing eating disorders using a variety of methods.**

  > *Address eating disorders through lectures, one-to-one counselling and referrals.*

- **Exposure of clients to alternative health therapies.** Key experts stressed the value of exposing clients to alternative therapies such as yoga, meditation, massage or acupuncture as ways of supporting exploration of health needs and finding solutions to problems.

9.1.2 Treatment Approaches to Address Personal (Including Mental Health) Issues

Although key experts identified many best practices to address emotional (including mental health) issues, there was consensus on only four approaches. Most of these approaches relate to mild to moderate mental health problems such as mild depression, anxiety and low self-esteem rather than more severe mental health disorders such as schizophrenia and severe depression.

In general, *group work* was considered to be the optimal method to explore personal issues. Groups provide empowerment opportunities for women, peer support and education. A smaller number of key experts identified one-to-one therapy as an important element of practice, especially to help women prepare for group work or in cases where women prefer one-to-one counselling as an adjunct to group work.

Key experts identified client *education* as an effective approach to address emotional issues. Education is a powerful tool to explore issues such as:

- the elements of a balanced life;
- patterns of violence (including generational abuse);

- methods of self-care;
- strategies for understanding relapse.

In addition, key experts identified the value of teaching *life skills* to this group. Life skills may include vocational skills, stress management, anxiety-reducing strategies, anger management and goal setting.

In terms of broad approaches, respondents identified a broad multi-dimensional approach to treatment (bio-psycho-social) as being the most effective.

9.1.3 Treatment Approaches and Methods to Address Interpersonal Issues (Peer and Family Relationships)

There was consensus around a number of approaches to address the interpersonal needs of clients. Best practices include:

- **The use of the "relational model" as a guiding approach.** Treatment should be oriented to understanding and supporting women to build healthy peer and family relationships. An aspect of this approach involves education about what constitutes a health (including a healthy sexual) relationship.
- **Provision of couples work and/or family therapy.** Key experts stressed the importance of providing couples work and family therapy if feasible, appropriate and supportive to clients.

  > *Need a place for women and men to go – into their own gender-specific group to explore issues, and then couples counselling.*
  >
  > ***
  >
  > *Try to get people in her life involved – she comes in with partner and family.*

- **A focus on practical skill building (life skills, assertiveness, employment and educational skills development).**

  > *If it comes up within group about how to get back into the workforce, so they'll go with it and put on a workshop and bring in some resource people who will show them how to write résumés, etc.*

- **A focus on experiential learning.** Respondents stressed the importance of providing an opportunity for clients to practice new skills and interactions with others.

  > *The person will be different when she goes back without self-destructive behaviour and interaction with the family will be different, so practice is important.*

- **Teaching of parenting skills.** These would include an understanding of children's developmental needs and re-parenting strategies.
- **Exploration of family of origin issues.** Women need to understand the linkages between their family of origin and how this impacts on parenting. This is particularly important for Aboriginal women where intergenerational issues may need to be addressed.
- **Exploration of identity and co-dependency and other identity-related issues such as spirituality.**
- **Provision of mental health services and resources for children.** Children are affected by substance use. Programs should offer services or referral to services so that these impacts can be addressed.

9.1.4 Treatment Approaches to Address Relapse Prevention/Management

Key experts identified best practices that support relapse prevention and management. Consensus occurred around general approaches rather than specific techniques. Best practices consist of:

- **A recognition among staff (addressed through program design) that relapse is likely to occur and can be a positive impetus for exploring client growth and change.**

  > *. . . big piece in here (our program) is to normalize it (relapse). We know that women slip (the rate is very high), so number one let them know it will happen – be aware of it and then develop new healthier ways of coping.*

- **A focussed approach to relapse prevention and management .** This includes the building of relapse prevention understanding and techniques *into* treatment from the point of program intake.

  Addressing relapse prevention involves helping clients understand:

  - that relapse happens for a reason;
  - the scenarios that trigger relapse;
  - alternative responses to relapse.

  > *Need to focus on developing skills to manage triggers, develop self-awareness, (i.e. what they are and then what to do to get out of trouble) just being abstinent doesn't give you the skills to deal with relapse.*

- **The use of a cognitive-behavioural approach to explore relapse triggers and responses.**

  Help clients observe triggers, plan what to do, practice how going to respond – a way to change behaviours.

- **Post-treatment support.** Respondents also emphasized the importance of a post-treatment support system to address relapse. Post-treatment support comprises three elements:
  - the provision of ongoing post-treatment counselling/support (out-patient counselling);
  - assistance by program staff in developing community connections for clients to support ongoing recovery.

    Provide lots of support in early recovery – encourage them to go to AA and get a relationship with sober women.

  - assistance in connecting women to life supports such as housing, money, vocational training that will support recovery.

    Need to look at the context of their environment (home, money) for relapse prevention, if supports not in place, plans won't work.

- **Other relapse prevention/management strategies.** Although there was no consensus on the following specific treatment methods to address relapse, several respondents mentioned the value of following:
  - educational methods, seminars to provide information on health issues;
  - use of group work to demonstrate what does or doesn't work;
  - motivational interviewing;
  - one-to-one counselling;
  - "narrative" approach to exploring issues about self;
  - stages of change model.

Table 9: Optimum Treatment Approaches: Key Expert Perspectives

Issues Addressed	Best Practice: Key Expert Perspectives
Physical health issues	➞ Offer menu of approaches and resources. ➞ Stress interrelationships between mind and body. ➞ Provide strong educational component (impact of substances on health). ➞ Stress nutritional counselling. ➞ Provide access to allied professionals to address specific health disorders. ➞ Support referral networks which address health issues. ➞ Support experiential learning and skills practice. ➞ Have specialized staff available on site (in-house physicians/staff, nurses). ➞ Provide specialized integrated approach to eating disorders. ➞ Introduce clients to alternative therapies.
Personal (mental health issues)	➞ Use bio-psycho-social approach. ➞ Support referral networks which address health issues. ➞ Support experiential learning and skills practice. ➞ Use group work to explore issues (using connections and support between women). ➞ Use one-to-one therapy for specific purposes (useful to prepare clients for group). ➞ Educational approaches (methods of self-care, generational abuse, balancing needs, handling relapse). ➞ Teach range of life (communication, stress reduction, assertiveness) and vocational skills.
Interpersonal issues	➞ Use relational model to explore issues. ➞ Support referral networks which address interpersonal issues. ➞ Provide education about healthy relationships. ➞ Provide couple counselling (where feasible, appropriate and non-destructive). ➞ Focus on practical skills building (e.g. vocational training). ➞ Support experiential learning and skills practice. ➞ Provide treatment services for children, where required. ➞ Facilitate exploration of parenting styles, family of origin issues. ➞ Facilitate exploration of identity and co-dependency issues. ➞ Facilitate exploration of spirituality.
Relapse prevention/ Management	➞ Build on philosophical acceptance of relapse. ➞ Support experiential learning and skills practice. ➞ Start relapse management education at intake. ➞ Stress that relapse happens for a reason. ➞ Identify trigger scenarios and healthy responses. ➞ Use cognitive-behavioural approach to identify and respond to relapse. ➞ Employ variety of methods (narrative, motivational interviewing, group work, education) to explore relapse. ➞ Structure aftercare for clients consisting of: ▪ post-treatment out-patient counselling; ▪ connections to community support and self-help; ▪ attention to basic life support issues.

9.2 Treatment Approaches and Methods: Literature Review

9.2.1 General Themes

Treatment approaches and methods are discussed broadly in the literature and may include structural approaches, treatment methods, treatment organization or staff characteristics.

Eliany and Rush noted that 50% to 60% of all patients (both male and female) in treatment show improvement, although, "there is no one treatment modality that has emerged as superior to all other approaches. (Eliany and Rush, 1992:79)

A review of several large-scale (U.S.) treatment effectiveness studies concluded that treatment is effective (although dropout is the rule). Successful (drug abuse) treatment includes a range of elements, such as:

- a comprehensive range of services including pharmacological treatment, group and individual counselling and HIV risk reduction education;
- case management;
- a continuum of services;
- provision and integration of continuing social supports.

This study suggested that all these elements "rather than the specific treatment models, determine whether a program will be successful in treating individual clients and affecting the broader, social community problems that exist because of drug abuse." (Office of the U.S. National Drug Control Policy, 1996:18)

In relation to women's treatment, Lightfoot et al. have noted it is difficult to determine the most effective treatment approaches for individual clients:

> Deciding whether or not a particular treatment is effective is an extremely complex task. Substance users vary dramatically at the beginning of treatment . . . descriptions of treatment interventions are frequently vague and implementation evaluation is seldom addressed. There is little agreement as to what treatment outcome objectives should include, and what constitutes success in terms of substance abuse treatment is hotly debated. (Lightfoot et al., 1996b:189)

The women's treatment literature identifies several broad approaches which are associated with treatment effectiveness (e.g. multi-component treatment models). Many of these have not yet been empirically demonstrated in the literature.

> There are a number of programs throughout the country that are attempting to set up comprehensive treatment models. To date, due to both a lack of funding, as well as the newness of some of these programs, there has been little evaluation of their effectiveness . . . . (Finkelstein, 1993:1289 - 1290)

In a review of seven comparative studies of treatment and seven randomized studies, Lightfoot et al. concluded that:

> Although these studies are few in number—a common finding appears to be that women do well, compared with men, in treatments that offer training in self-management, develop coping and relapse prevention skills and address personal needs. (Lightfoot et al., 1996b:195 - 196)

9.2.2 Specific Treatment Approaches and Methods Identified in the Literature

This section provides a description of the following treatment approaches commonly associated with effective treatment outcomes and identified in the literature:

a) Multi-component Treatment Model;
b) Gender-sensitive or Gender-specific Treatment;
c) Use of Cognitive-Behavioural Approach;
d) Use of Pharmacologic Agents Where Required (and in cases of women who are pregnant and are injecting drugs);
e) Collaborative and Case Management Approach;
f) Appropriate Client Treatment Matching;
g) Provision of (Practical) Adjunctive Services;
h) Positive, Hopeful and Empathic Staffing;
i) Specialized Staff Training;
j) Empowerment Model;
k) Addressing Sexual Abuse and Other Experiences of Victimization;
l) Addressing Family Issues;
m) Additional Elements of Best Practice.

a) Multi-component Treatment Model

There is a strong consensus in the literature that effective treatment must include a range of direct and indirect treatment services to address a range of client needs (biological, mental health, peer, family and personal). Reed (1987), Zankowski (1987), Finkelstein, (1993), Drabble (1996), Nelson-Zlupko et al. (1996), Swift and Copeland (1996), identified the core service areas which they consider integral to effective treatment. These have been summarized and annotated below (Table 10). Not all these services need to be provided *within* one program; however, the services need to be made available within a comprehensive and integrated system. Finkelstein (1993) described over 50 components of this comprehensive care system for women, many of which are described below. However, she noted that:

> There is little discussion or agreement in the literature as to how such disparate services should be linked into the model. (Hagen et al. as cited in Finkelstein, 1993:1289)

b) Gender-sensitive or Gender-specific Treatment

Substance abuse research has revealed that the impact of substances on women and their treatment needs differ from those of men.

Health problems caused by alcohol/drug misuse have a more rapid onset and become more serious in a shorter period of time.

Women who misuse substances are also more likely to have a history of victimization. Research has also noted that women respond differently than men to treatment settings. Jarvis, in a meta-analysis of 20 outcome studies that distinguish between men and women, concluded that women in treatment tend to act differently in co-ed treatment settings and to minimize their focus on treatment issues.

> Females in mixed-sex groups showed less (*sic)* interactions with other women, a decreased amount of discussion about home and family and less overall interaction. (Jarvis, 1992:1255)

In a study of a co-ed hospital-based treatment program, Zankowski (1987) speculated that the low completion rate among women clients was due to a lack of gender-specific programming. The program was restructured to include the following gender-specific components:

Table 10: Summary of Core Elements of Effective Treatment for Women

- **Medical/Health services**
  - nutrition
  - health promotion services
  - sexuality education
  - hiv/aids education
  - reproductive health education
  - prenatal care
- **Child-Related services**
  - child care
  - treatment services
  - parent education
- **Family issues**
  - couple counselling
  - family therapy
  - exploration of familial substance use patterns
- **Education/Skills training**
  - assertiveness
  - goal setting
  - stress reduction
  - communication skills
  - survival skills
  - relapse prevention
- **Psycho-Social issues**
  - self-esteem development
  - exploration of shame and guilt
  - exploration of victimization issues
  - exploration of addressing co-existing problems (e.g., depression and anxiety)
  - address victimization issue
- **Community support connections**
  - exploration of social and leisure needs
  - establishment of linkages to recreation, leisure and social service organisations
- **Vocational and employment support training**
  - job-seeking skills
  - job training
    - ➥ education
    - ➥ referrals
- **Addressing life needs**
  - referrals/support to acquire housing, monetary support or legal assistance
  - assistance with child care
  - transportation needs
- **Special services required for diverse populations**
  - exploration of cultural values and interrelationship with use and treatment

- **Speciality seminars** for women (to address substance misuse impacts, self-esteem, family relationships, making it "on your own," parenting role conflict, identification of feelings, sexuality, birth control, family communication and vocational planning).
- **Assertiveness training** in all women's groups.
- **Leisure activities programming** (to address low female participation, fear of male harassment, exploration of preferences).
- **Family intervention counselling.**
- **Individualized attention to affective disorders** most relevant to women.

The inclusion of these elements increased the completion rate of women clients.

Nelson-Zlupko et al. (1996), in a study of treatment experiences of 24 women in recovery, reinforced the importance of women requiring a forum for expression of women's needs and experiences. Eighty percent of her subjects found discussion of women's issues very helpful or helpful; 75% found women-only groups very helpful or helpful. The women, all of whom had received treatment in women-specialized programs as well as traditional programs, preferred the former. Copeland and Hall (1992), in a retrospective study of predictors of treatment dropout of 360 women seeking alcohol/drug treatment, found that certain groups of women were more likely to complete treatment at specialized gender-sensitive treatment services.

> Women with a history of sexual abuse in childhood appear to have an increased need for a physically and emotionally safe environment as their trust has been seriously violated in the past. (Copeland and Hall, 1992:809)

For lesbians and women with dependent children, "attendance at a specialist women's service reduced the incidence of dropout" (Copeland and Hall, 1992:833).

In a study of 267 women who had received treatment, Swift and Copeland (1996) found that the women, who had been in women-only treatment positively endorsed women-specific programming. Within the larger sample of all women who had received treatment (N=217), 42% did not have strong feelings about co-ed or women-only treatment. Eighteen percent liked socializing with men; 11% felt mixed programs were more balanced. However, 11% felt unsafe in co-ed programs. Ten percent who had previously dropped out of treatment said they would have stayed longer if there had been fewer male clients.

Dahlgren and Willander (1989) reported that participants in a specialized all-female program were more likely to report abstinence at 12-month and 2-year follow-ups than women in a control group undergoing treatment at a "traditional" mixed-sex treatment centre.

c) Use of Cognitive-Behavioural Approach

Although the cognitive-behavioural approach to treatment was broadly supported by key experts, no specific empirical data assessing the efficacy of this approach, *specifically* with women, was found. In a review of the treatment outcome effectiveness evaluation literature (related to both men and women), Eliany and Rush noted that: behaviourally oriented treatment approaches for alcohol problems have received the most support from evaluation studies.

> In general terms, the evidence confirms one of the expectations drawn from social learning theory that "performance-based" treatment methods are superior to more traditional, "verbally-based" methods such as psychotherapy or education. Behavioural approaches that are generally supported by the literature include family and marital therapy, aversive therapy, contingency management, and broad-spectrum treatment focusing on relaxation training, stress management and a range of skills training (e.g., social skills, problem-solving skills). (Eliany and Rush, 1992:79)

Similarly, in a recent review of the literature (Health Canada, 1999) examining the effectiveness of treatment modalities, good evidence of effect was associated with the following behavioural modalities. Many of these are identified as elements within an "empowerment" approach:

- social skills training;**
- self-control training;*
- brief motivational counselling;
- behavioural marital therapy;
- community reinforcement approach;
- stress management approach.*

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* Are elements of the empowerment approach.

d) Use of Pharmacologic Agents Where Required (and in cases of women who are pregnant and inject drugs)

Hagen et al. stated that alcohol/drug treatment providers often show a negative bias toward using psychotropic drugs, although there may be indications for their use in some cases. In a study of impediments to a comprehensive treatment model, she suggests that there are clear advantages to using psychotropic medications:

> Psychotropic medications assist in reducing depression while the woman learns to cope with emotions she has previously medicate.... with legal drugs (e.g. alcohol). (Hagan et al. 1994:168)

The literature also identifies methadone maintenance therapy as an important treatment approach for women who are heroin drug users. Methadone assists in the management of withdrawal from heroin, reduces criminal involvement, improves physical and psychological well-being and enables opiate users to focus on social and vocational rehabilitation (Office of the U.S. National Drug Control Policy, 1996).

Svikas et al. (1997), in a study of incentives for pregnant, drug-dependent women, found that methadone-maintained women attended nearly two times more days in treatment than non-methadone-maintained women and stayed in treatment longer. Hagan et al. (1994) noted that methadone may be a useful tool for clients to control cravings and life chaos. Methadone may also ensure better prenatal outcomes (although methadone use during pregnancy requires careful monitoring). Laken et al. (1996), in a non-comparison study, isolated five factors that contributed to retention for a group of pregnant women and found that the use of methadone (provided to women addicted to heroin), organized case management and transportation to treatment were three of the factors that contributed most strongly to retention in treatment.

e) Collaborative and Case Management Approach

Laken et al. (1996) identified strong case management as a key element of effective substance abuse treatment for pregnant women. She defined the following components as integral to a strong case management approach.

- staff assessment of client need for health and social services;
- planning and coordination of services;
- monitoring of services to clients (through home visits and calls);
- advocacy on behalf of clients;

- provision of tangible supports to assist access to services (e.g. funding, transportation).

f) Appropriate Client Treatment Matching

The literature supports the importance of matching treatment approaches with the needs of people with substance use problems. Mattson and Allen (as cited in Waltman, 1995) concluded that matching of clients' needs to treatment increases the treatment success rate by 10%. Treatment matching appears to work best for people with moderately severe substance use problems. Waltman considered the following tasks as most important to consider when matching clients to treatment:

- a consideration of the needs of special populations (e.g. needs of women, ethno-cultural groups);
- respect for client-defined choices (self-matching);
- the assessment of the client's need for structure (includes an assessment of client's loci of control, conceptual level and type of alcoholism);
- substance use severity level;
- stage of recovery;
- level of client self-esteem.

g) Provision of (Practical) Adjunctive Services

Milby et al. (1996), in a study of the homeless (primarily using crack cocaine), 20% of whom were women, found that therapy enhanced with specific practical supports was more likely to engage clients in treatment, although long-term retention rates for the groups involved in this study were low.

h) Positive, Hopeful and Empathic Staffing

In a survey of 24 women in recovery, Nelson-Zlupko et al., found that the quality of staff/client interactions was described as the most important factor within substance abuse treatment settings.

> The gender, age, race and substance abuse history of the counsellor, while viewed as important characteristics, were collectively perceived as less important than the extent to which the counsellor treated them with dignity, respect and genuine concern. (Nelson-Zlupko et al., 1996:55)

Experiences with good counsellors were perceived by clients as connected to increased use of treatment and even sobriety. In a general study of client dropout from treatment, Allerman, O'Brien and McLellan (as cited in Waltman, 1995) identified three staff characteristics associated with client dropout from treatment:

- hostility/confrontational style;
- lack of empathy;
- low level of expectancy and hope for change.

i) Specialized Staff Training

Staff with specific skills and training may be required to provide treatment to groups with specialized needs. Women with concurrent disorders require such specialized skills. Grella, in a study of women with concurrent psychiatric and substance (drug/alcohol) abuse disorders, found that both substance abuse treatment and mental health staff required specialized skills.

> [Treatment] Staff . . . need training on psychiatric assessment and diagnosis, pharmacologic treatment approaches, stages of recovery in mental illness and the effects of trauma. Mental health treatment staff need training in detoxification procedures and effects, assessment of addiction and differences in types of addiction, role of self-help and 12-step programs and stages of recovery from addictions. (Grella, 1996:331)

j) Empowerment Model

Drabble surveyed treatment providers with the objective of identifying the elements of an effective residential recovery program for women with alcohol use problems. She found that the empowerment model was closely associated with positive treatment experiences and outcomes.

> Respondents tended to identify the concept of empowerment as critical to the recovering individual as well as important to the philosophical basis and design of programs. (Drabble, 1996:17)

Although broader in focus, Strantz and Welch (1995), in a study of treatment retention among postpartum women, found that a multi-dimensional model which incorporated the philosophy of women's empowerment was most closely associated with treatment retention.

> Treatment type was a very strong predictor of treatment retention and outcome. Almost half of the women admitted to the (intensive) program completed treatment; compared to one out of five from the (non-intensive) program. The (intensive) program incorporated a myriad of elements, such as a cognitive-behavioural approach; an *empowerment of women philosophy*; parenting role models and support; professional/paraprofessional, mostly female staff; and comprehensive support services such as childcare, transportation and medical, social and educational services. (Strantz and Welch, 1995:372)

k) Addressing Sexual Abuse and Other Experiences of Victimization

Research has reported that women requiring treatment are frequently survivors of sexual abuse (rates vary from 34% - 86% depending on the study). Carson, Council and Volk (as cited in Jarvis, 1992), Copeland and Hall, (1992); Russell and Wilsnack (as cited in Drabble, 1996) found that a history of incest was associated with low self-esteem, particularly for women who are alcohol dependent. Young (1990) suggested that there is a strong relationship between incest experiences and substance misuse.

Miller et al. in a study of the interrelationships between experiences of childhood victimization and the development of women's alcohol-related problems, found that two thirds of the women with alcohol use problems had experienced some form of childhood sexual abuse as compared to one fifth or one third of two other samples without alcohol use problems. Nearly half (45%) of the sample, identified as having alcohol-related problems, compared to 13% and 18% of the non-drinking samples, reported severe paternal violence. The rates of childhood victimization were significantly greater for women in treatment with alcohol-related problems when compared to women in mental health treatment without alcohol-related problems.

> Thus, even when holding the treatment conditions constant, childhood victimization has a specific connection to the development of women's alcohol-related problems. These findings remained significant even when controlling for demographic and family background differences, including parental alcohol-related problems (Miller et al., 1993:115).

l) Addressing Family Issues

Drabble (1996) noted that educational sessions and group counselling around partner and parenting issues were considered by clinicians she interviewed as a core treatment component for women with alcohol use problems. However, Swift and Copeland's (1996) study on treatment needs (identified by women themselves) determined only that the provision of child care services would have increased retention in treatment (family counselling was not identified).

Seventy-six percent of 24 women in recovery (Nelson-Zlupko et al., 1996) described family counselling as a helpful component of services. However, other services such as transportation, help obtaining food, housing and clothing and recreational services were rated as helpful by a high percentage of the women clients.

m) Additional Elements of Best Practice

Other approaches, such as harm reduction and the relational model, identified by key experts are not, at this time, addressed in the empirical research, although elements of these models (client choice, importance placed on family and child relationships) have been addressed to some degree in this document.

10. Client Retention in Treatment

10.1 Summary of Key Expert Perspectives

Key experts were asked to identify the treatment approaches, methods or organizational structures that supported women *staying* in treatment. Most of the issues identified have already been described in previous Sections 8.0 and 9.0; thus, they are summarized below. Literature relating to this topic is also covered in these sections and is not replicated here.

Key experts stressed the importance of client/treatment matching as one of the most critical elements of client retention in treatment. Program staff need to assess, in collaboration with clients, their specific needs and provide resources and approaches which meet those needs without using a pre-formulated plan. Needs may not always be interpreted or described in the same way by staff and clients. Flexibility and choice must be offered.

Table 11: Best Practices to Support Treatment Retention: Summary of Key Expert Perspectives

- Treatment is flexible—allows women to move in and out as required.
- Treatment provides child care services or support.
- Treatment is provided to children, where this is required.
- Treatment is client centred and individualized.
- Treatment supports women's empowerment—identifying life goals and developing the skills and insights to achieve them.
- Treatment is provided in the context of relationships with family and others.
- Treatment addresses the way women see and treat each other—establishing connections and trust is important.
- Relapse is not a defining point in recovery.
- Treatment offers a menu of services.
- Treatment addresses practical issues (e.g. money, housing, employment).
- Treatment looks at small goals and short-term success.
- Treatment (or a significant component of it) is gender specific.
- Treatment is matched specifically to client need.
- Treatment discharge is planned in advance.
- Staff have respectful and collaborative relationships with clients.
- Staff encourage and integrate continuous client feedback.

11. Treatment Organization and Duration

11.1 Treatment Organization and Duration: Key Expert Perspectives

11.1.1 Treatment Organization

- **Continuum of services.** Key experts were overwhelmingly of the view that there is no one way to organize treatment but that a range of choices, organized along a continuum of care (from least intensive to most intensive services), should be offered. Services used would be based on a consideration of client choice and the extent and severity of the substance use disorder.

Key experts identified the following forms of treatment as integral to this continuum of services.

- withdrawal management services;
- respite "crisis beds";
- community-based out-patient treatment;
- mobile (off-site) treatment;
- intensive day treatment;

- residential treatment;
- aftercare services (including sober housing support, long-term contact with program);
- support services such as child care and transportation.

- **Out-patient or Residential Models.** Where respondents did identify preferences, the out-patient treatment model was considered to be most effective for the majority of clients:

> *Women living in their own environment (if safe): that's good for them, less artificial. It allows them to work on other areas of their lives.*

One key expert noted that the goals of residential treatment could be accommodated in many out-patient settings. Again, an opportunity for choice is an important factor.

> *Often women go to residential care because they are not offered choice – what works is what the client thinks will work (e.g., they have a new (intensive) program that is two days/week). In the past, these women would have gone into long-term residential treatment which would take away their lives.*

However, several key experts noted that residential care needs to be available for women with more severe problems, or for those living in unsafe environments. "Residential" could also include short-term "crisis beds."

> *For many women, by the time they get into treatment it has gone on for a long time, and by then she needs longer-term in-patient care.*
>
> ***
>
> *Need some crisis beds in a safe environment – for example, if over a weekend a woman feels like she just can't handle things, then there would be some very short-term beds available.*

- **Same Sex or Co-ed Treatment.** Key experts emphasized the importance of providing women-only treatment or, at a minimum, specialized components of women-only treatment in co-ed settings.

> *Treatment should be women focussed, but not all women see this. Some women enjoy co-ed AA, but in the end their true sense brings them to women-specific programs.*

Deficiencies of a co-ed setting include a lack of focus on women's experiences and issues and exposure of women to an unsafe treatment environment.

> *Co-ed treatment may create unhealthy relationship dynamics – increased attention-seeking behaviour (vulnerability looks pleasing). Not possible to feel safe in a co-ed environment. Relationships likely – would take focus off self – (should be) discouraged in early recovery.*

There was some degree of consensus on the value of mixed-group treatment in *specific* situations.

> *Co-ed treatment may enhance awareness that male/female emotions are similar and reduce over-generalizations about men and enhance healthy understanding of men. May enhance likelihood of productive therapy – potential for growth and healing.*

According to another respondent:

> *When session is informational, co-ed is positive; when session is process-oriented, needs to be gender-specific.*

One key expert suggested that there needs to be support to both gender-specific and gender-sensitive programming.

> *Need to find way to deal with women on two levels: gender-specific programming and more gender sensitivity in every program. Programs that have both genders say their programs are better, more flexible, women doing better, men doing better.*
>
> *Mixed gender later on in treatment can be helpful. Women are going to have to think about how to behave with men – need to work on it, practice it. But need to be explicit re timing of when to include men in the program. Don't throw the women into mixed setting. Have an all-women's setting to talk about how they are going to act in mixed setting. Then, in pairs they go into a mixed group, come back to women's group and discuss how it went.*

11.1.2 Treatment Duration

There was a strong consensus that residential treatment should not be less than four weeks in length with many key experts advocating a standard length of at least five weeks. Out-patient would require three to six months or longer (up to one to two years in some cases). However, respondents stressed that flexibility is the key to planning treatment length, not rigid standardization.

> The literature says four to five weeks, but must have a system where you phase people in and out of intensity — standards don't always work.

11.2 Treatment Organization and Duration: Literature Review

11.2.1 Treatment Organization

- **Out-patient and In-patient Treatment.** There has been little agreement on the optimal organization of treatment (in-patient, day treatment or out-patient) within the literature. Previous reviews on the relative effectiveness of treatment in in-patient and out-patient settings (Saxe et al., and Annis, Miller and Hester both cited in Finney et al., 1996) have found that:

> There was no evidence for the superiority of in-patient over out-patient treatment of alcohol abuse, although particular types of patients may be treated more effectively in in-patient settings. (Finney et al., 1996:1774)

Finney et al. analysed 14 studies that examined in-patient versus out-patient treatment. No differentiation was made for men or women. Only seven studies found treatment setting effects.

> . . . the significant results were mixed, with five studies finding in-patient/residential treatment to be superior and two finding day hospital treatment to be more effective. (Finney et al., 1996:1793)

However, a more important factor resulting in positive outcomes (regardless of setting) is the *intensity* of treatment provided. Finney et al. noted that research is still lacking in the area, especially in relation to variations on traditional out-patient and in-patient settings.

> . . . studies are needed that compare different forms of residential treatment or different forms of out-patient treatment . . . studies of alternatives within each type of setting should examine potential mediators and moderators of effects. For example, it may be that in-patient treatment is more effective for people with serious medical or psychiatric impairment because it reduces such symptoms more than does residential treatment. (Finney et al., 1996:1792 - 1793)

Kissin (as cited in Finney et al., 1996) reported that socially competent patients experienced better outcomes in out-patient treatment whereas socially unstable patients had better outcomes following in-patient treatment. Strantz et al. (1995), in a study of postpartum women, found that an intensive day treatment model was more effective for crack-dependent women than a conventional out-patient counselling model in terms of client retention treatment.

- **Gender-specific Treatment.** There is support in the literature for the effectiveness of gender-specific treatment settings, although limited empirical research has been conducted in this area. Swift and Copeland's (1996) survey of Australian women who had received treatment found that most women (80%) had no preferences for treatment type. Choice was considered to be the most important factor.

Dahlgren and Willander (1989) compared 200 women in gender-specific treatment with women attending treatment at mixed-sex centres. Women treated in the specialized unit showed significant improvements (in comparison to women in mixed-sex treatment) in the following areas:

- over time, a lower rate of alcohol consumption (number of days abstinent at years one and two);
- smaller amounts of alcohol consumed at relapse;
- fewer blackouts, mood disorders;
- fewer relapses.

More women from the women-only treatment group managed to drink in a "cautious, social way" without apparent negative impacts during the observation period (one to two years) after treatment.

There is evidence that women and men respond differently to treatment when men are involved. Aries (as cited in Jarvis, 1992) compared women and men in same-sex and mixed-sex groups. She reported that:

> Females in mixed-sex groups showed less interaction with other women, a decreased amount of discussion about home and family, and less overall interaction.

All female groups showed a greater flexibility in the rank order of speaking, more one-to-one interactions and self-revelations about feelings and relationships. (Jarvis, 1992:1255)

Duckert and Johnson (as cited in Jarvis, 1992), in a study of alcohol-dependent subjects, showed that:

> Male groups were reported to be more task oriented while females used the group setting to discuss life issues, arrange contact outside treatment and to organize practical assistance with child care and transport. (Jarvis, 1992:1255)

Considering the importance of group connections and family issues to women, the implicit conclusion is that the group dynamics occurring in a mixed group may have deleterious effects. Baily (cited in Jarvis, 1992) speculated that women may derive emotional and social support from all-female groups. The need for support is highlighted by studies that identify the social costs and isolation experienced by women entering treatment. (Beckman and Amaro, 1986)

Swift and Copeland (1996), in a study of 267 women who had received assistance for alcohol and drug abuse, found that of the women who had attended women-only programs, 40% valued the programs as a way to relate to other women and 35% felt the programs were more safe. Only 8% were concerned that the programs did not reflect the reality of the mixed-sex world. Forty-two percent had no strong feelings about mixed-sex programs, although 11% felt uncomfortable or unsafe in such programs.

In a comparison of predictors of treatment dropout of women seeking treatment in a specialist and mixed-sex setting, Copeland and Hall (1992) concluded that personal variables were most likely to be associated with treatment dropout. For lesbian women, women with a history of sexual assault in childhood, and those with dependent children attendance at a gender-specific treatment facility led to lower dropout rates.

11.2.2 Treatment Duration*

Again, there is limited literature addressing optimum treatment length *specifically* related to treatment for women. The establishment of optimum treatment duration is related to factors such as client need, substance use characteristics, and costs associated with treatment.

Miller and Hester (as cited in Eliany and Rush, 1992) compared outcomes of short and long in-patient stays and found that shorter stays were as effective as long-term stays. Some studies using non-random, matching designs have suggested that longer treatment may have a modest advantage.

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* For forther information, see Best Practices - Substance Abuse Treatment and Rehabilitation (Health Canada, 1999)

Mosher et al. (cited in Spooner et al., 1996) compared 200 men and women with alcohol use problems assigned to 9-day and 30-day residential programs. At 3- and 6-month follow-ups, there were no differences between the groups in terms of abstinence. Page and Schwab (as cited in Spooner et al., 1996) compared the effect of a 3- and 5-week residential program. The results showed little difference in client drinking at 6-month follow-up.

In a review of Treatment Outcome Perspective Data, Condelli and Hubbard (1994) analyzed the relationship of time spent in treatment to treatment outcome. The research considered both male and female clients in therapeutic communities. The research found that the longer clients who used drugs spent in therapeutic communities, the less likely they were to use heroin, cocaine, marijuana and psychotherapeutic drugs and the more likely they were to be employed full time and to have committed no predatory crimes during the follow-up year.

Gerstein and Harwood (as cited in Simpson et al., 1997) noted that length of stay in community-based drug abuse treatment is one of the best predictors of treatment outcomes. Simpson et al., in a study of 435 patients after discharge from three methadone treatment programs, found that:

> Daily opioid users who spent a year or longer in methadone treatment were five times more likely than patients with shorter treatment to have better behavioural outcomes at follow-up. (Simpson et al., 1997:238)

Previous findings from national treatment programs also suggest that 12 months is a significant retention threshold for methadone treatment. However, Simpson et al. noted that there were patients with relatively brief treatment exposure who also showed improvement over time.

Long et al. (1998) compared the effectiveness and cost-effectiveness of a five-week in-patient and two-week in-patient and day patient design for male and female alcohol-dependent patients. Abstinence or non-problem drinking was achieved by 55.6% of all participants at one year. There was no correlation between program delivery and outcome, suggesting that the shorter program is only more cost-effective. The sample was moderately socially stable, suggesting that this group may be over-treated in more intensive programs.

Sanchez-Craig et al. (1989) found some evidence for the efficacy of brief alcohol treatment approaches for women who met the criteria for this type of intervention. Her study compared the relative effectiveness of three brief approaches:

- **Guidelines approach** (3 sessions of advice using a pamphlet);

- **Manual approach** (3 sessions of instruction plus self-help manual);
- **Therapist approach** (6 + sessions of training on procedures to reduce drinking).

At 3, 6 and 12-month follow-ups, females were generally more successful than males in reducing their days of drinking after using the brief approaches described in the manual. They were more successful in using the "guidelines" and "manual" approaches than men and showed better outcomes.

The variability of the literature clearly suggests that relationships between treatment outcomes and duration are based more on appropriate client/treatment matching rather than a standardized approach. As noted by Eliany and Rush:

> One of the overriding conclusions from the review of this literature is that, given the diversity of the population seeking treatment, not all types of interventions or programs will necessarily be effective for all types of individuals in need of assistance. (Eliany and Rush, 1992:67)

12. Critical Adjunctive Services Required by Women in Treatment

12.1 Critical Adjunctive Services: Key Expert Perspectives

The literature related to women's treatment strongly endorses the importance of a multi-component set of services, a "menu" of options for women requiring treatment (see Section 9.0). These resources may be accessed by clients within or through programs. Respondents were asked to identify the most important adjunctive services (see Table 12.)

Table 12: Critical Services Identified by Key Experts

- Vocational skills development and resources (vocational training, high school completion, job readiness)
- Mental health services and resources
- Health services to address physical health needs
- Counselling/training/education related to parenting skills, re-parenting
- Connections to social services support
- Child care services (during and after treatment)
- Assistance in finding safe and affordable housing
- Family support services
- Support to access financial maintenance

12.2 Optimum Methods of Providing Adjunctive Services: Key Expert Perspectives

Key experts identified a strong collaborative approach between program staff and other resources and professionals as the best method of assisting clients to access support services. The components of the collaboration were described as being based on:

- ongoing community information sharing and networking;
- the identification of appropriate resources and points of referral;
- the development of a shared sense of understanding and purpose (in collaboration with referral contacts);
- development of effective referral protocols;
- the identification of leaders within the collaborative network.

A collaborative approach to utilizing resources is the basis for effective case management where there is a central entry point followed by case planning, case management and follow-up. Key experts also recommended the development of a range of in-house programs and resources to address needs. In-house child care, some educational health and general resources (transportation costs) were sometimes provided by programs themselves.

> *Integrate some into the treatment program (e.g. handling of dual diagnoses, sexual abuse, eating disorders) but some need to be addressed in the community, some need to be addressed in post-treatment as well.*

Key experts also felt a client empowerment approach helps clients to access and use services.

> *Inform client about resources. Do not do the leg work for them – instead, empower them by clarifying what they want and instructing them on resources. Put client in control to make choices and accept consequences.*

13. Measuring Treatment Effectiveness

13.1 Measuring Treatment Effectiveness: Key Expert Perspectives

Best practices are always judged in relation to a concept or concepts of "what works" for clients in treatment. Key experts were asked to identify the factors which need to be measured in order to demonstrate treatment effectiveness.

Many key experts noted that measuring treatment effectiveness was a problematic area, in part due to difficulties they experienced tracking clients post-treatment and a lack of clarity on what measurement indicators to use. Key experts believe in a multi-dimensional approach to treatment assessment but are not sure how to weigh or

integrate factors in order to provide a "complete picture" of client outcomes. There is also the recognition that many aspects of treatment impact are qualitative and that there are few standardized tools available to measure qualitative outcomes. In addition, pressures to use standardized (quantitative) tools are growing.

> *Need a standardized way of measuring outcomes – from intake – very difficult to measure abstract things in concrete ways funders want.*

Some key experts noted that *not* using abstinence as a "final" treatment outcome measure has made treatment outcome measurement more complicated.

> *If we're not going to use abstinence as a measure, then we need to measure how and why they are using – need to make judgment on the harm being done. Need to focus on context and consequences of use – look for reductions in amount used, signs of controlled use, signs woman is thinking about negative consequences, reactions, safety of children . . .*

Key experts identified the following areas to be considered in a comprehensive assessment of client outcomes after treatment:

- improvement in physical health status (e.g. eating patterns, disease management);
- improvements in (healthy) family relationships;
- gains in employment or in acquisition of vocational skills;
- improvements in self-esteem (including hope for future);
- abstinence or reduction in use;
- harm reduction (less risk behaviour and presence of a workable relapse plan), ability to protect self, even if using substances;
- decrease in criminal involvement;
- broad lifestyle changes (improvement in housing, leisure, recreation and activities, increased ability to handle stress);
- improvement in quality of life (as assessed by client).

13.2 Measuring Treatment Effectiveness: Literature Review

There is a lack of data addressing outcome measurement within women's treatment. According to Finkelstein et al.:

> Outcome data on gender-specific programming remains scarce as most of the (U.S.) programs with evaluation components, primarily federally- funded, have not yet completed their evaluation process. (Finkelstein et al., 1997:25)

There is the recognition that outcome indicators need to measure more than abstinence. A broader view of outcome measures would include:

- consumption patterns;
- fluctuations in abstinence;
- amount of alcohol consumed post-treatment;
- number of days abstinent;
- improvement in role performances, physical symptoms;
- relationship and family problems and legal problems. (Finkelstein et al., 1997:25)

The Treatment Outcome Perspective Study summarized in the *Treatment Protocol Effectiveness Study* (Office of the U.S. National Drug Control Policy, 1996), which reviewed major national research results and solicited clinical and research opinion, identified the most relevant outcome measures (see Table 13).

Table 13: Defining Effective Drug Use Treatment

Adapted from *Treatment Protocol Effectiveness Study*
(Office of the U.S. National Drug Control Policy, 1996)

Overall Outcome	Definitions
• Reduced use of primary drug	➞ Abstinence ➞ (Longer) length of time to relapse ➞ Reduced frequency of use ➞ Reduced amount of drug used in total and during each episode of use
• Improved functioning of drug users in terms of employment	➞ Increased numbers of days worked ➞ Enrolment in training programs or school (if required)
• Improved educational status	➞ Increased numbers of days (in school) ➞ Enrollment in training programs or school (if required)
• Improved medical status and general improvement in health	➞ Fewer hospitalizations ➞ Fewer doctor visit ➞ Fewer emergency room visits
• Improved mental health status	➞ Improved mood recognition ➞ Reduced psychotic status ➞ Improved personality traits ➞ Reduced need for mental health treatment
• Improved non-criminal public safety factors	➞ Reduced incidence of drug-related motor vehicle accidents, emergency room visits, fines

The following indicators of treatment effectiveness were cited as being particularly applicable to men and women with more serious drug problems:

- reduced crime;
- reduced drug use;
- reduced domestic violence;
- reduced at-risk behaviour;
- increased days of employment;
- positive changes in social values and networks.

The timing of measurement of outcomes is another important methodological issue. Hser et al., in a study of gender and ethnic differences in responsiveness to methadone maintenance, examined multi-outcome longitudinal data in relation to temporal patterns to assess treatment success (rather than single-point-in-time comparisons). He concluded that:

> Society is concerned with drug abuse not only because it causes health problems for individual addicts, usually at public expense, but also because it is associated with various other social and criminal consequences. Therefore, multiple outcome measures, including several aspects of drug use, social functioning, and criminal justice system involvement, should be examined in any intervention evaluation study. In addition, because the pattern of chronic compulsive narcotics use typically involves relapse after a period of abstinence in an often-repeated cycle, evaluation findings based on the single criterion of abstinence at a single observation point are inadequate; in fact, they may be artificially distorted simply by the length of the follow-up observation. A more reasonable evaluation approach is to reflect each of these multiple outcome measures as a probability function over time; a further step involves identifying explanatory factors or predictors that may contribute to the observed probability functions. Survivorship analysis provides a useful technique for the statistical analysis of those types of duration measures. (Hser et al., 1990-91:1310)

Changes in outcome measurement must be predicated on new expectations of treatment and clients. Merrill believed that society's expectations of "total and permanent abstinence are too high."

> Treatment is expected to be a combination of an antibiotic and a vaccine: complete cure and no chance of relapse. In part, this results from the fact that society views substance use disorders as acute problems, rather than as chronic disease with acute episodes. (Merrill, 1998:175)

To address this, Merrill concluded that:

> We must move away from looking at this at the individual level of someone permanently stopping drug use, and, instead start applying outcome criteria appropriate to other chronic medical candidates and viewing these outcomes from the broader societal level. (Merrill, 1998:175)

Preliminary research (Merrill, 1998) indicates that while methadone maintenance may not completely eliminate heroin use, the HIV seroconversion rates are lower for those in treatment. A second study (Alterman as cited in Merrill, 1998) indicates that the *number* of times a client has been in treatment is significantly correlated with reduction in recidivism. These outcome results reinforce the value of looking at outcomes in a more flexible and multi-dimensional (and less clinical) way.

14. Summary of Model Program Elements

The attached table provides a summary of the model program elements as described by respondents with references to supporting literature. Literature references may not equate exactly with the elements identified so it is advised that readers review these within the text.

The best practice elements defined in this table are based on respondent comments. In some cases, the literature suggested other issues, included in the text but not in the table.

Table 14: Model Program Elements

Underlying Principles of Treatment (All Components)	• **Menu of options** (Finkelstein et al. 1997) • **Menu of approaches** (Office of Reed, 1987; Zandowski, 1987; Drabble, 1996; Nelson-Zlupko et al. 1996; the U.S. National Drug Control Policy, 1996; Swift and Copeland, 1996; Finkelstein et al., 1997) • **Harm reduction model** (Creamer and McMurtrie, 1998; Lightfoot et al., 1996b) • **Holistic** (Covington, 1998; Creamer and McMurtrie, 1998) • **Addresses practical needs** (Booth et al., 1992; Schleibner, 1994; Nelson-Zlupko et al., 1996; Swift and Copeland, 1996) • **Gender specific** (Dahlgren and Willander, 1989; Copeland and Hall, 1992; Jarvis, 1992; Schleibner, 1994; Nelson-Zlupko et al., 1996; Swift and Copeland, 1996; Finkelstein et al., 1997) • **Supports connections between women** (Covington, 1998) • **Supportive, collaborative, non-hierarchical** (Finkelstein et al., 1997; Covington, 1998) • **Based on empowerment model** (Schliebner, 1994; Strantz and Welch, 1995; Drabble, 1996; Finkelstein et al., 1997; Creamer and McMurtrie, 1998) • **Respectful** (Kasl, 1995) • **Client driven** (Mattson and Allen in Waltman, 1995; Finkelstein et al., 1997; Creamer and McMurtrie, 1998) • **Supports client education and awareness** • **Based on strengths, not deficits** (Finkelstein, 1993) • **Uses feminist approach (see gender specific above and empowerment)**

General Component of Treatment	Program Accessibility	Principles of Treatment	Approach and Methods	Outreach
Client Contact and Engagement	• **Multidimensional publicity strategy** • **Broad outreach for publicity (multiple venues)** ➞ **Focus on confidentiality** ➞ **Publicize range of treatment options** ➞ **Range of formats** ➞ **Toll-free line** ➞ **Mother's needs emphasized** (Finkelstein et al., 1997) ➞ **Solution focussed** • **Flexible and open treatment entry** (Waltman, 1995; Grella, 1996) • **Timely and structurally accessible treatment** (Waltman, 1995; Swift and Copeland, 1996; Grella, 1996)	• **Women centred** (Schliebner, 1994; Swift and Copeland, 1996; Finkelstein et al., 1997; Covington, 1998a and b) • **Culturally appropriate** (Ja and Aoki, 1993) • **Realistic objectives** • **Women's empowerment approach** (Finkelstein et al., 1997; Creamer and McMurtrie, 1998)	• **Menu of options** (Schliebner, 1994; Swift and Copeland, 1996; Finkelstein et al., 1997; Covington, 1998a and b) • **Offer practical (life) supports** (Booth et al., 1992; Nelson-Zlupko et al., 1996; Swift and Copeland, 1996)	• **Collaborative approach with physicians** (Thom, 1986; Smith, 1992; Allen, 1994) • **Linkages with other community agencies** (Smith, 1992; Allen, 1994) • **Direct (street) outreach to clients** (Booth et al., 1992; Finkelstein et al., 1997)

General Component of Treatment	Program Accessibility	Principles of Treatment	Approach and Methods	Outreach	Family
Treatment Approaches and Methods			• **Educational approaches (health, healthy relationships and nutrition)** (Drabble, 1996) • **Nutritional education** • **Individualized multi-dimensional approach to eating disorders** • **Exposure to alternative therapies (see Menu of Approaches)** • **Psycho-bio-social approach** • **Relational model** (Zankowski, 1987; Covington, 1999) • **Practical skill-building approach** (Zankowski, 1987; Adam et al., 1999) • **Focus on experiential learning** • **Provisions of services for children (see Menu of Approaches) and understanding** • **Acceptance of relapse** • **Cognitive-behavioural approach** (Eliany and Rush, 1992) • **Post-treatment support** (Office of the U.S. National Drug Control Policy, 1996)	• **Referral to specialists (see Menu of Approaches)** • **Specialists on staff** • **Build post-treatment community support** (Office of the U.S. National Drug Control Policy, 1996)	• **Couples work and family therapy** (Zankowski, 1987; Smith, 1992; Schliebner, 1994; Nelson- Zlupko, 1996) • **Exploration of parenting styles**

General Component of Treatment	Program Accessibility	Principles of Treatment	Approach and Methods	Outreach	Staff/Client Relations	Family
Retention in Treatment (many themes repeated above)		• **Client-centred and individualized (see above)** • **Relapse not defining point in treatment (see above)** • **Menu of options (see above)**	• **Flexibility at entry (see above)** • **Women's empowerment model (see above)** • **Practical issues (see above)** • **Gender specific (see above)** • **Client treatment matching** • **Discharge planned in advance**		• **Staff respectful and egalitarian** • **Staff encourages continual feedback**	• **Needs of children considered priority** (Swift and Copeland, 1996) • **Treatment provided in the context of relationships (see above)**
Treatment Organization and Duration		• **Continuum of services to meet client need** (Waltman, 1995; Office of the U.S. National Drug Control Policy,1996; Finkelstein et al., 1997; Creamer and McMurtrie, 1998)	• **Out-patient preferable structure** • **In-patient best for high-need groups** (Kissin in Finney, 1996) • **Gender specific treatment see above under gender specific)** • **Well-planned co-ed involvement** • **5-week duration (residential)** Miller and Kessler in Eliany and Rush, 1992 • **Out-patient 3 - 6 months** (Gerstein and Harwood in Simpson et al., 1997)			

General Component of Treatment	Program Accessibility	Principles of Treatment	Approach and Methods	Outreach	Staff/Client Relations	Family
Adjunctive Services Required			**Services required: (See Menu of Options above)** • **Vocational/education** • **Mental health services** • **Health services (physical health)** • **Counselling/training/education related to parenting;** • **Connections to social services and family support** • **Child care services** • **Housing;** • **Financial support (see Menu of Services above)**			
Organization of Adjunctive Services			• **Collaborative approach (information sharing, common purpose, established referral networks** (Booth et al., 1992; Waltman, 1995; Laken, 1996; Finkelstein et al., 1997) • **Agency provides some services in-house** • **All services co-located** • **Empower clients to use services** (Booth et al., 1992)			

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