

Predictors of Retention: What Research Says About Women with Substance Use Disorders

Deborah Werner
Children and Family Futures
4940 Irvine Blvd., Ste 202 * Irvine, CA 92620
714.505.3525 * dwerner@cffutures.org

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Agenda

- History
- Gender Differences in use, addiction & treatment
- Framework for Women's Services
- Critical Factors in Retention

30 Year History of Women and AOD Treatment

Early Years

- 1944 Marty Mann, first woman to achieve lasting sobriety in AA founded National Committee for Education on Alcoholism (now NCADD).
- 1951 Bea Grey Jorgenson opened Friendly House in Los Angeles, first all woman recovery House.
- 1960 Very few services available to women – and those that were available were provided in co-ed programs where women received the same treatment as men.
- 1965 The McAteer Alcoholism Act set up outpatient alcoholism programs around the state.

1970's Women's Services Emerge

- 1970 The Hughes Act created NIAAA, large-scale federal funding for alcohol programs, required plans and funding for under-served populations including women.
- 1970s 45 alcohol programs for women were opened with newly available funds through NIAAA and 14 demonstration drug treatment programs for women are funded including 2 for women with children.
- 1979 California passes law making spousal rape a crime.

1980s: Learning About Women

- Prior to the 80s, virtually no research addressed women. Early studies often omitted women.
- 1980 Community Prisoner Mother Program: TCs for female felons and children < 6.
 - 1982 First Lady Betty Ford opens the Betty Ford Center.
 - 1984 1980s Expansion of domestic violence programs offer a feminist model of services for women.

1980s Expansion of Perinatal Services

- 1986 Select Committee on Perinatal Alcohol-Related Birth Defects convened leaders and experts to identify causes, impacts and solutions to alcohol-related birth defects and form recommendations.
- 1988 Anti-Drug Abuse Act of 1988 created model projects for pregnant/post-partum women and infants. 28 programs in California received funding.
- 1988 The California Health and Welfare Agency established the State Interagency Task Force on perinatal substance abuse.
- 1990 SB 2669 (Presley) requires hospitals to address perinatal alcohol/drug use.

Increased Research & Knowledge

- 1993 Perinatal Substance Exposure shows 29,494 pregnant women in 202 hospitals throughout California had positive drug/alcohol tests at the time of delivery.
- 1994 CSAT develops "the comprehensive treatment model" which was included in the 1994 CSAT publication *Practical Approaches in the Treatment of Women who Abuse Alcohol and Other Drugs*.
- 1994 Institute for Health Policy Studies at UCSF evaluation of the California Perinatal Services Network final report.
- Flurry of Journals & articles on women's alcohol and drug use and treatment services.

Other Impacts in Services

- 1995 OJ Simpson acquittal spurred increase in domestic violence awareness and policy.
- 1997 AB 1542 enacted CalWORKs to implement federally required welfare reform.
- 1997 Adoption & Safe Families Act Promoting Safe & Stable Families shifts federal policy emphasizing child safety over keeping families together.
- 1998 Judge Milliken established the Dependency Court Recovery Project in San Diego.
- 1998 The Drug Court Partnership Act of 1998 results in 34 Drug Courts.
- 1998 Proposition 10 passed by voters.

Coming to the Present

- 2000s Increased recognition of motivation and engagement as critical components.
 - 2000s Awareness of prevalence and relevance of trauma in women's addiction and treatment.
 - 2000s Emergence of Evidence Based Practices Implementation Kits & Research.
 - 2004 CSAT revised Comprehensive Model for Women and Their Children. (Not Published).
 - 2006 SAMHSA National Women's Conference held in California.
- Approximately 100 journal articles per quarter address women's alcohol and drug issues.

The Roots of Our System

- Treatment services in California today evolved from three sources:
 - alcohol services which emerged through Alcoholics Anonymous and followed a social model approach,
 - drug abuse services which evolved from early therapeutic communities, and
 - clinical approaches which were initiated through privately funded hospital based programs.
- All three approaches created a male-centered model of services and then adapted it to serve women.

California Compared with the Nation

	CALIFORNIA 2004	NATIONAL 2004
Percent Female Admissions	34.7	31.5
Percent of Facilities with a Specific Women's Program or Group	31.0	30.2
Percent Females Pregnant at Admission	5.4	3.8
Percent of Facilities with Pregnant/ Postpartum Women's Specific Program or Group	20.2	14.1

Sources: Online analysis of TEDS 2004 (admissions); online analysis of N-SSATS (programs).

Gender Differences in Use, Addiction & Treatment

Prevalence

- 6.1% of women in the US were dependent on or abused alcohol or other illicit drugs. (OAS, 2005b) Women represent 33.4% of total population with substance use disorders.
- Women's lower rate of dependency and abuse may be explained because males have more opportunity to use drugs than females. (Wetherington, 2006)
- This is changing with younger age groups. Among youth aged 12-17 rate of illicit drug use for was equal for boys and girls (10.6%) and alcohol use was slightly higher for girls (18.0% compared with 17.2% for boys). (NSDUH, 2004)

Why Girls/Women Initiate Use

- Young women use substances to:
 - improve mood
 - self-medicate mood disturbances
 - increase confidence
 - lose inhibitions
 - enhance sex
 - lose weight
 - Access to alcohol and other drugs
 - Partners, boyfriends & peers encourage use
 - Higher incidence of dependency associated with child abuse and neglect

Telescoping Effect

- Greater severity – women enter substance abuse treatment at generally the same ages as men, but with shorter substance use histories and more severe consequences.
- Years between first regular use and first treatment was 3.5 years for men vs. 2.8 years for women
(Grella & Joshi, 1999)
- Women look for help in different places. More likely to be referred by another community service agency, less likely to be referred by family or criminal justice.

Gender Differences at Entry

- ❑ Reasons cited for not getting treatment by women classified as needing but not receiving treatment and who felt a need for treatment included:
 - ❑ 33% felt not ready to stop using
 - ❑ 27% felt could handle the problem on their own
 - ❑ 22% were concerned with stigma (compared to 10% of men)
 - ❑ 17% could not afford treatment
 - ❑ 9 % did not have time (compared with 2% of men)
 - ❑ 8% did not know where to go, 7% indicated the program type unavailable, 4% no openings and 4% transportation.

Source: Online analysis of the NSDUH 2003 Public Use file

Women Compared to Men At Treatment Entry

- ❑ Higher levels of psychological distress – depression, suicidal attempts
- ❑ Less likely to have graduated high school
- ❑ More problems in social and family functioning
- ❑ Almost half as likely to be employed
- ❑ More health problems
- ❑ Weekly or daily illegal activity (but less likely to be involved with criminal justice system)
- ❑ More likely to report physical and/or sexual abuse

Wechsberg et al., 1998; Grella et al., 2005

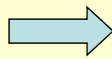
Barriers to Treatment for Women

- Pregnancy
- Child care
- Other family responsibilities
- Economic barriers
- Co-Occurring disorders
- Trauma
- Social stigma and discrimination
- Low Self-efficacy

Treatment for Women

GENDER DIFFERENCES

- Biological
- Psycho-social
- Parenting/Family
- Motivators & Barriers
- Treatment Needs
- Recovery Support Needs



SERVICE RESPONSES

80s/90s Gender Specific:

- Separate facilities
- Separate groups/services
- Childcare

2000s Gender Responsive:

- Trauma Informed
- Strengths Based
- Relational Theory

Adapted from Christine Grella, Ph.D., What's so Special About Specialized Treatment for Women presented at National Conference on Women, Addictions and Recovery, July 2006.

Two Frameworks

- Public Health Approach
- CSAT Comprehensive Model for Women and Their Children

Public Health Model

Problem exists when an Agent interacts with a Host in an Environment

- Agent– alcohol or other drugs
- Host - Individual who is susceptible to an AOD problem. Often surrounded by families
- Environment – family, social and community environment including media and peers

Strategies to prevent, reduce and treat alcohol and other drug problems address all three areas.

Public Health Interventions

Individuals

- building protective factors
- reducing risk factors
- treatment

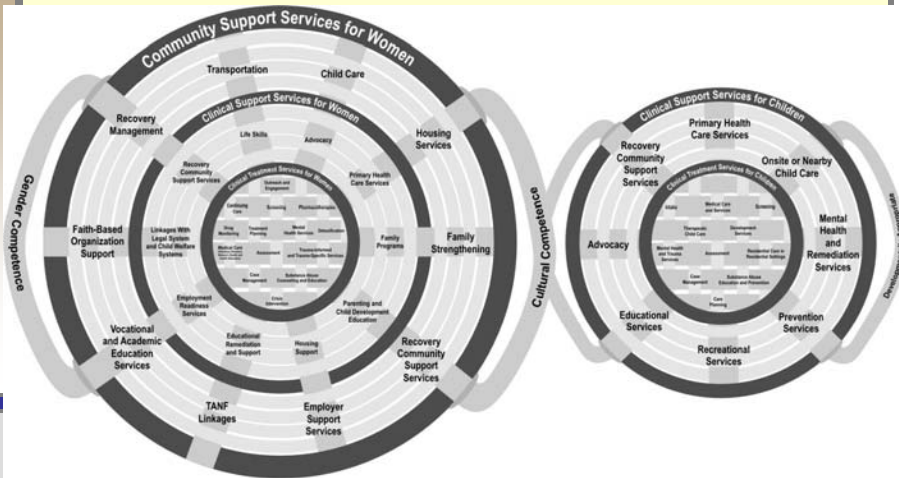
Agents

- Alcohol policy (formal and informal)
- Interdiction

Environments

- building environments which discourage problem use
- supportive social networks
- healthy community messages

CSAT Model of Comprehensive Services for Women & Children



CSAT Women, Youth and Families Task Force (2004). Unpublished draft.

Comprehensive Model includes:

Components

- Clinical treatment services for women
- Clinical support services for women
- Community support services for women
- Clinical treatment services for children
- Clinical support services for children
- Community support services for children

Cultural Competence, Gender Competence and Developmentally Appropriate

- A substantial body of research identifies unique characteristics of women with substance use disorders

Gender Responsive Treatment

Characteristics of Gender Responsive Services

Relational

- Strength-based, motivational
- Comprehensive
- Trauma informed
- Address the different pathways to use, consequences of use, motivation for treatment, treatment issues and relapse prevention needs unique to women
- Provided in an environment where women feel comfortable and safe

Culturally Relevant Treatment

- Honors traditions and values
- Acknowledges cultural pain and racism
- Builds appropriate efficacy and support
- Staff, management and Board reflective
- Respects individuals
- Differentiates drug culture from culture itself
- Helps people learn cultural traditions
- Relational

Clinical Treatment Services

FOR WOMEN

- Outreach and Engagement
- Screening
- Pharmacotherapies
- Drug monitoring
- Treatment planning
- Mental health Services
- Detoxification
- Medical Care and Services
- Assessment
- Substance Abuse Counseling and Education
- Trauma Informed and Trauma-Specific Services
- Crisis Intervention
- Case Management
- Continuing Care

FOR CHILDREN

- Intake
- Screening
- Medical Care and Services
- Therapeutic Child Care
- Development Services
- Mental Health and Trauma Services
- Assessment
- Residential Care in Residential Settings
- Case Management
- Substance Abuse Education & Prevention
- Care Planning

Clinical Support Services

FOR WOMEN

- Life skills
- Advocacy
- Primary health care services
- Family programs
- Parenting and child development education
- Housing support
- Education remediation and support
- Employment readiness services
- Linkages with legal system and child welfare systems
- Recovery community support services
- Life skills

FOR CHILDREN

- Primary health care services
- Onsite or healthy child care
- Recovery community support services
- Advocacy
- Educational services
- Recreational services
- Prevention services
- Mental health and remediation services

Community Support Services

- Transportation
- Child care
- Housing services
- Family strengthening
- Recovery community support services
- Employer support services
- TANF linkages
- Vocational and academic education services
- Faith based organization support
- Recovery management

Family Treatment – the Next Evolution

Continuum of family involvement to family treatment

- Services for all family members
- Family therapy and support
- Dynamic, different members may come at different times
- Requires a new way of looking at clients

Critical Factors in Retention

Medical Treatment Compliance

Insulin Dependent Diabetics

- Compliant with medication < 50%
- Compliant with diet & foot care < 30%
- Retreated in 12 months 30 - 50%

Hypertensives

- Compliant with medication < 30%
- Compliant with diet < 30%
- Retreated in 12 months 50 - 60%

Other Chronic Conditions

Compliance with Medical Treatment

- > 50% of "re-occurrence" was due to lack of compliance
- > 50% of medical patients lie about compliance

Reasons for Disease Re-Occurrence

- 1 - Lack of Compliance
- 2 - Socioeconomic Factors
- 3 - Family Support
- 4 - Psychiatric Co-morbidity

Predictors of Women's AOD Treatment Retention

INDIVIDUAL CHARACTERISTICS

- Higher financial resources and income
- Fewer mental health, family, health or social problems
- Personal stability, older age
- Less severe drug problem
- Criminal justice referral

(Greenfield, 2006)

PROGRAM CHARACTERISTICS

- Child care
- Woman-focused day treatment
- Residential treatment accommodating children

We Know More about Women Seeking Treatment

- Lack of self-esteem and self-efficacy
- Intergenerational addiction
- Pregnant or caretakers of children
- Relationships that encourage use and are unsupportive of treatment
- History of trauma and childhood abuse
- Co-occurring disorders, PTSD
- Lack of intervention strategies or treatment options
- May need- economic, parenting, life-skills & housing for recovery support

Predictors of Positive Outcomes

Treatment retention and length of treatment – biggest predictor of positive outcomes

Program Associated Characteristics

- Child care, prenatal care
- Comprehensive programming & mental health services
- Residential programs accommodating children
- Women only programs & programs offering supplemental women-focused services

(Ashley, Marsden & Brady, 2003)

Women with less trauma or psychiatric problems have better abstinence outcomes

(Greenfield et al, 2002)

Selected Factors in Retention

- Engagement
- Relationships
- Trauma
- Co-Occurring Disorders
- Case Management & Comprehensive Services

Engagement Factors

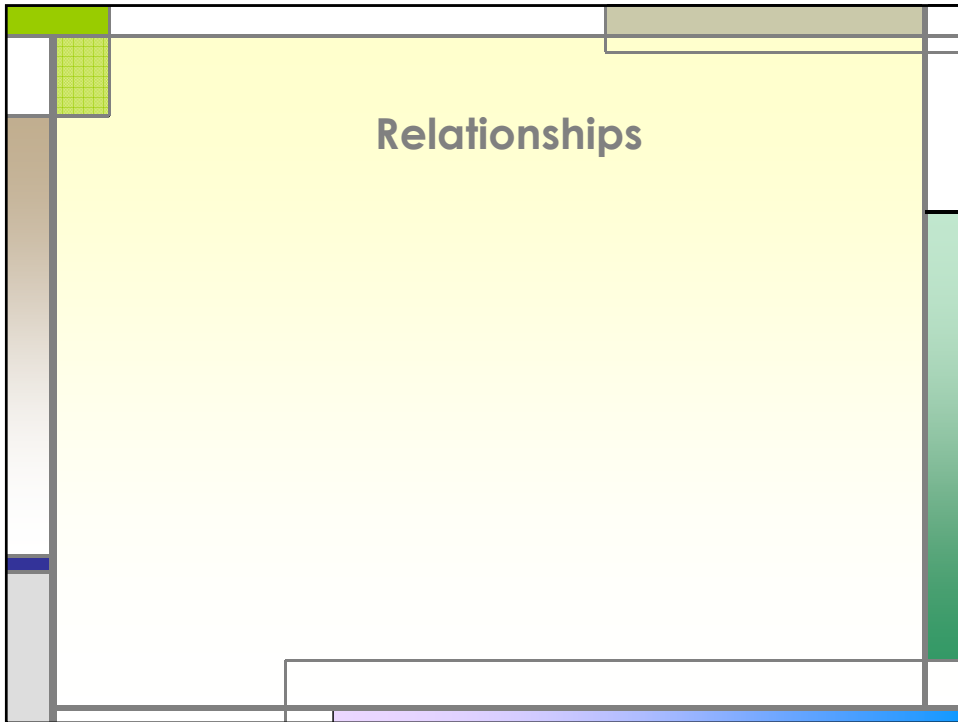
- Perceived utility of treatment
- Ancillary services
- Empathetic counseling style (for women)
- Motivational interviewing

Motivation and Engagement

Suggested additional factors

- Address low self efficacy and low self-esteem
- Multiple avenues for engagement – planting seeds. Do not need to “hit bottom”
- Building trusting relationships
- Allow client to develop locus of control
- Fight stigma, judgment, stereotypes

“They took my baby and now he has a home, food, people to take care of him. I have nothing. There is no one to help me.”



Relationships & Support Network

Women, compared to men, are:

- More likely to report onset of drug use and encouraged use from spouse and partners.
- Less likely to report pressure from spouse to enter treatment
- Less likely to report help/support from family or friends
- More likely to report that family or friends used drugs in the past year

(Grella & Joshi, 1999)

Family & Support Network

- Women recover in supportive relationships.
- Researcher's consistently find that treatment effects, participation and sustained recovery outcomes all improve when a partner/family participates in treatment.
- Engagement of family members improves relationships, provides necessary support for women.
- "If we build it they will come" does not work – must engage family members.

Involvement of Children

- Children are both an incentive and a barrier to participating in treatment.
- Multiple treatment studies have demonstrated that better outcomes are achieved by women who have all of their children with them.
- Many children have therapeutic treatment needs.
- Parenting support and coaching on parent/child relationship allows for improved parenting, confidence, esteem and reduced stress. A history of past child abuse may interfere with substance abusing women's parenting ability.

Building Relationships

- Women are relational by nature
- Developing a primary relationship is critical component of engagement
- I will comply with treatment “for you” or someone else
- Therapeutic alliance
- Building a peer support network. Women learn by listening and talking with others.
- Support network is critical for long term recovery

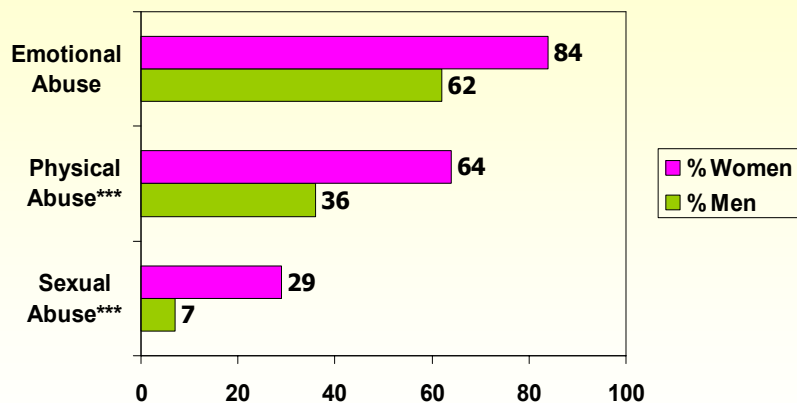
Trauma

Trauma

Women in substance abuse treatment are more likely to report a history of trauma (usually physical or sexual abuse) than general population of women.

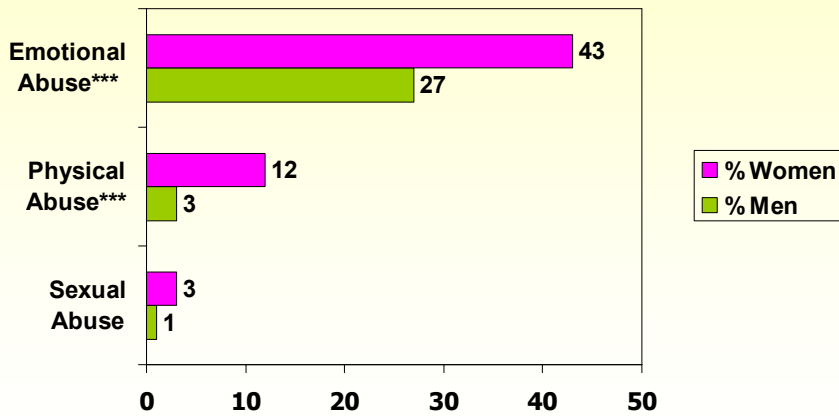
An estimates range from 55-99% of women in treatment compared with 36-51% of women in general. (Najavits, 1992)

Gender Differences in a Treatment Population: Abuse During Lifetime



*** significant difference between women and men $p < .001$

Abuse During Past 30 Days



*** significant difference between women and men $p < .001$

Judith Cohen, Ph.D. Presentation to NASADAD June 2005

Addressing Trauma

- Trauma should be treated as present rather than the exception. The majority of women in treatment have experienced substantial trauma--either childhood abuse/neglect and/or sexual traumatic experiences
- Create safe environments
- Support clients to identify triggers, self-soothe, ground and remain in treatment
- Offer specialized, therapeutic trauma services
- Provide mental health services as needed

Trauma Programs

- Clark, C., Fearday, F. (eds) (2003) *Triad Women's Project: Group facilitators manual*. Tampa, FL: Louis de la Parte Florida Mental Health Institute, University of South Florida. (contact Colleen Clark at cclark@fmhi.usf.edu)
- Covington, S. S. (2003) *Beyond Trauma: A Healing Journey for Women*. Center City, MN: Hazelden Press. (Contact Stephanie Covington at sscird@aol.com)
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Trauma Programs continued

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Co-Occurring Disorders

Prevalence

- 45% of women with illicit drug dependence or abuse had a SMI, compared to 22% of men
- 31% of women with alcohol dependence or abuse had a SMI, compared to 15% of men
- Approximately 2% of the adult female population has a co-occurring mental health and substance abuse problems

(Office of Applied Studies, 2004)

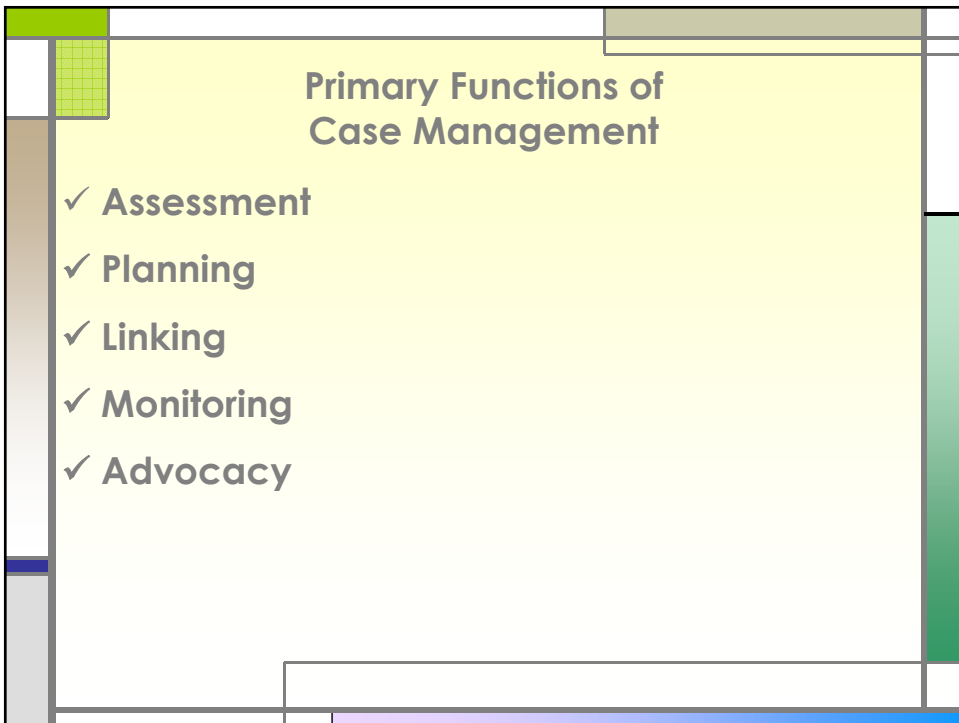
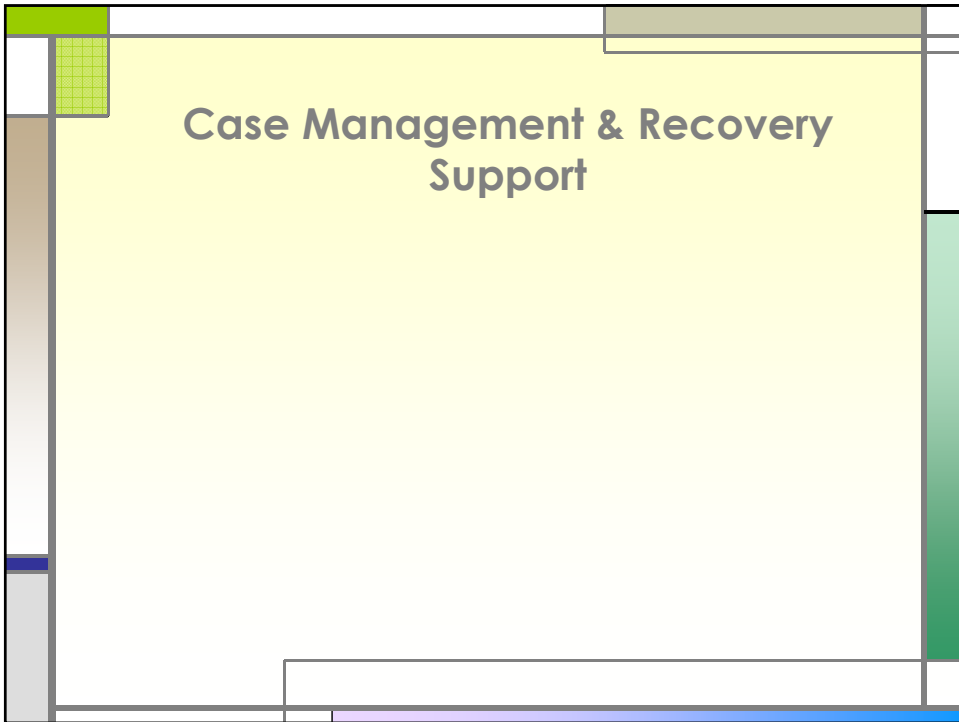
Eating Disorders

- Up to 35% of substance abusers have an eating disorder (vs. up to 3% in the general population)
(National Center on Addiction and Substance Abuse, 2003)
- Weight control is cited as a reason for drug use, among young women
- Young women with eating disorders are more likely to have problems with alcohol and drugs than their peers

Co-Occurring Disorders & Retention

- Screening and Assessment
- Treatment Planning
- Individualized Services – Are clients being asked to do things they cannot do?
- Integrated Mental Health/Substance Abuse Services
- Motivational Counseling
- Case Management
- Integrated Co-Occurring Disorders Treatment Evidence Based Treatment Implementation Kit

<http://www.mentalhealth.samhsa.gov/cmhs/communitysupport/toolkits/cooccurring/>



Supportive Case Management

- Support and encourage participants in their endeavors.
- Keep tasks simple.
- Define the case manager's role. Be aware of your limitations.
- Listen. Assess. Don't judge.
- Be available, conduct home visits, return calls.
- Keep commitments. Don't make promises.
- Provide structure and guidance.
- Offer to demonstrate.
- Remove barriers.

Recovery Support

- | | |
|--|--|
| <input type="checkbox"/> After Care and Alumni Programs | <input type="checkbox"/> Child care |
| <input type="checkbox"/> Relapse Prevention | <input type="checkbox"/> Income maintenance and emergency needs assistance |
| <input type="checkbox"/> Supportive Relationship Network | <input type="checkbox"/> Vocational, academic education services |
| <input type="checkbox"/> Housing | <input type="checkbox"/> Faith based organization support |
| <input type="checkbox"/> Family Strengthening | <input type="checkbox"/> Recovery management |
| <input type="checkbox"/> Employment and vocational support | <input type="checkbox"/> Crisis Intervention |
| <input type="checkbox"/> Transportation | <input type="checkbox"/> Advocacy |
| <input type="checkbox"/> Safe Communities | |

Chronic Care Model

- Addiction is a chronic disease
- Recovery requires treatment and on-going maintenance
- Regular follow-up after treatment can address worsening of condition
- Individuals with substance use disorders have prevention, intervention, treatment and maintenance needs throughout their lives

Alumni and After Care Services

- Maintaining Primary Relationships
- Follow Up Counseling Sessions
- Alumni Support Groups and Recreational Activities
- Alumni Support for Programs
- Continued Engagement Services – isolated clients
- Attending Meetings Together
- Peer Support Post Treatment
- What can WE do for YOU?
- Always call before _____

Relapse Prevention

- Importance of social supports and networks for women
- Need to address violence/abuse issues while in treatment to help prevent relapse and improve
- Depression, negative feelings and interpersonal problems are more common relapse triggers among women (vs. anxiety and positive feelings among men)
- Developing personal identity and sense of value central to on-going recovery

Comprehensive Development

- Knowledge
- Skills
- Attitude
- Efficacy and Sense of Worth
- New Habits Emerge with Time

do for ... do with ... cheer on

Gender Responsive Treatment

- A substantial body of research identifies unique characteristics of women with substance use disorders

Characteristics of Gender Responsive Services

- Relational
- Strength-based, motivational
- Comprehensive
- Trauma informed
- Address the different pathways to use, consequences of use, motivation for treatment, treatment issues and relapse prevention needs unique to women
- Provided in an environment where women feel comfortable and safe.

Enjoy the Workshops

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