DOCUMENT RESUME

ED 205 860 CG 015 351

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TITLE Women and Drug Abuse Treatment: Needs and Services. Services Research Monograph Series.
INSTITUTION National Inst. on Drug Abuse (DHEW/PHS), Rockville, Md. Div. of Resource Development.
REPORT NO DHHS-ADM-81-1057
PUB DATE 81
NOTE 29p.
AVAILABLE FROM Superintendent of Documents, U.S. Government Printing Office, Washington, DC 20402.

EDRS PRICE MF01/PC02 Plus Postage.
DESCRIPTORS Career Counseling; Counseling Services; Day Care; *Delivery Systems; *Drug Abuse; *Drug Rehabilitation; Educational Counseling; *Females; *Human Services; *Individual Needs; Medical Services; Needs Assessment; *Rehabilitation Programs

ABSTRACT

During the 1970s, several activities were initiated in response to concern about the quality of treatment services available to drug-abusing women. A comparison of services needed by women with services actually available to women found that special treatment services for drug-abusing women were needed in the areas of medical treatment, counseling, employment, and child-care services. Nationwide female-oriented drug programs were identified, and staff members from 21 drug-free and 4 methadone maintenance programs completed questionnaires about demographics, drug use, and treatment services available for women in treatment during a 3-month period. Results indicated that the majority of the 547 female drug abusers received basic drug treatment services, i.e., routine medical examinations and drug counseling. About half received psychological and family counseling; one-third received skills assessments and educational counseling. However, large percentages had not received such essential services as opthalmological and gynecological examinations, birth control counseling, and dental care. Most received no vocational counseling or job and educational placement services. Few programs served the children of female clients. Significant differences were found in the delivery of services according to program type. (NRB)

SERVICES RESEARCH MONOGRAPH SERIES

Women and Drug Abuse Treatment: Needs and Services

by
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U S DEPARTMENT OF HEALTH AND HUMAN SERVICES
Public Health Service
Alcohol Drug Abuse and Mental Health Administration

For sale by the Superintendent of Documents, U S Government Printing Office
Washington, D C. 20402

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DHHS Publication No. (ADM) 81-1057
Printed 1981

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INTRODUCTION

In the early and mid-seventies, a number of activities were initiated in response to the growing concern about the quality of treatment services available to drug-abusing women. This concern was reflected at the First National Conference on Women and Drug Concerns, held in May 1973 in Washington, D.C. At this conference a feminist caucus group proclaimed that women must generate their own expertise, especially in the drug field, where they are "bombarded with male identified tests studies, and treatment programs founded on sexist philosophies." Ten months later, in March 1974, a special section on women's concerns was incorporated into the National Drug Abuse Conference held in Chicago. Following the Chicago conference, a series of State conferences focused on the special treatment needs of drug-abusing women.

At about the same time (1974), the National Institute on Drug Abuse established a Program for Women's Concerns to coordinate women's activities. The new office organized a national conference held in Miami in 1976 to identify the treatment needs of drug-abusing women and the techniques, programs, and resources that have special relevance to female drug abusers.

Legislation was passed in 1976 (Public Law 94-371) giving priority consideration to the funding of women's treatment and prevention programs. In addition, it was stipulated that State surveys should be structured to identify the "need for prevention and treatment of drug abuse by women and that programs be designed to meet such a need."

What impact have these efforts had? What has been learned about the particular treatment needs of drug-abusing women? To what extent have those treatment services, identified as being needed by drug-abusing women, been established?

The authors examine these questions from two perspectives, comparing the services needed by women with the services that are actually available. The paper is therefore structured into two sections (1) a review of the treatment needs of women as these needs have been identified in the literature, and (2) an exploratory study on the availability of services that meet the particular needs of drug-abusing women.

CHAPTER 1

A REVIEW OF THE TREATMENT NEEDS OF WOMEN

MEDICAL

In studies of treatment populations, investigators have found that women are more likely than men to cite physical problems as the reason for entering treatment. Brown et al. (1971) reported that drug-dependent women indicate drug-related physical problems as the reason for entering treatment 27 percent of the time compared to 19 percent for males. In addition, 50 percent of the women in their study (compared to 22 percent of the men) reported that drug-related physical problems were the reason for their first withdrawal. In another study involving drug clients in Philadelphia, physical health was cited as the primary reason for entry into treatment by 69 percent of the female drug abusers compared to 31 percent for male addicts (Flaherty et al. 1978). Wilson and McCreary (1976) report that the addict lifestyle is characterized by neglect of normal hygiene, health, and nutrition. Based on studies by different investigators, Dickey and Sowder (in press) concluded that the following health problems were the most prevalent medical disorders for addicted women infection, anemia, venereal disease, toxemia, hepatitis, preeclampsia, hypertension, and diabetes.

It has been speculated that prostitution, which is viewed as more prevalent among drug-abusing women than nonabusers, increases the probability of physical pathology, especially infection of the gynecological and urinary systems. Several investigators (Gossop et al. 1974; Santen et al. 1975; and Stoffer 1968) have reported that drug-abusing women are at greater risk for cervical and uterine malignancies as well as other gynecological problems, including a high level of dysmenorrhea. In a study of 205 medical records of female clients, Andersen (1977) learned that gynecological problems were present in 43 percent of the women admitted to treatment.

Many investigators have reported the need for birth control services. Stryker (1979) reported that 30 percent of former clients in the Hutzel Hospital Pregnant Addict Program were returning for their second or third unplanned pregnancy. In a study of prostitutes who abused drugs, James (1979) found that 76 percent failed to use contraceptive devices.

In an investigation conducted by Andersen (1977) it was learned that dental problems were reported by 42 percent of the women. These women found it particularly difficult to obtain dental services since most dentists refused to treat clients who were on public assistance medical insurance--the costs for dental services were too expensive for most clients. Thirty-eight percent of the women studied by Andersen had eye problems; large percentages of these women had suffered eye trauma and needed glasses

Minimum requirements for the delivery of medical services to drug-abusing women, however, have been established at the Federal level. The Federal Funding Criteria for Drug Treatment Services Guidelines (1975) stipulate that physical examination "shall be administered by qualified personnel as soon as practicable, but not later than 21 days after admission. Furthermore, programs should provide female patients with an opportunity to receive a complete obstetrical/gynecological examination. This examination should consist of at least an internal examination, Pap smear, and a breast examination Referrals for other germane services (e.g., prenatal care) should be a matter of course."

COUNSELING

Female drug abusers require counseling services that address their problems as drug abusers as well as needs specific to women. The development of trust in a continued, sustained relationship with a skilled counselor or psychotherapist who can provide understanding, acceptance, support, and guidance, and on whom the client can rely for help, has been found to be essential for achieving positive changes in the behavior and lifestyle of all drug abusers. In rehabilitation programs someone must assume direct responsibility for assessing the needs of clients, coordinating services (internally and externally), and fostering continuity of care. In drug treatment programs, this is generally the counselor's role. In fact, for many drug programs, the counselor is the primary service provider. Unfortunately, there is little information available in the literature on the quality and/or effectiveness of counseling services, nor even much systematic reporting of the methods of counseling that are utilized, nor of the process of counseling and psychotherapy.

However, the need for special counseling services for drug-abusing women has been demonstrated in recent studies conducted by the Women's Drug Research Coordinating Project (Reed and Moise 1979). These WDR studies show that drug-abusing women have more personal distress than comparison women and lower self-esteem than comparison women or addicted men (Colten 1979).

Carroll (in press), who conducted a comprehensive literature review of psychosocial and personality studies comparing alcohol- and drug-dependent persons, concluded that the common core underlying all forms of substance abuse is a negative self-concept. He suggests that the primary goal of treatment should be to

restore self-respect, helping clients achieve a personal sense of self and dignity. Numerous studies indicate that self-esteem is a significant problem among drug-abusing women (Mondanaro 1976; Bahma and Gordon 1978; Reed and Moise 1979, Burt et al. 1979). It has been found that addicted women have fewer personal resources and skills than comparison women for coping with psychological distress--depression, anger, anxiety--or with practical problem situations (Tucker 1977). Addicted women also rate themselves low on traits associated with ego strength. The effects of this negative self-perception by drug-abusing women obviously should have an impact on counseling techniques.

Bahma and Gordon (1978) concluded that rehabilitation from heroin addiction is especially difficult for women. The years in prison and the life in the addict subculture have a profound effect on female addicts' self-image and on their feelings as women. They require assistance with the essential aspects of daily living--help with child care, birth control, nutrition, managing on a limited budget, acquiring training or employment, etc. Some investigators (Eldred et al. 1974) concluded that assistance in obtaining available financial assistance and social services, for example, food stamps, should be a basic component of treatment programs serving addicted women.

There is a growing body of literature on the relationship between family disorganization and addiction (Aron 1975; Chein et al. 1964; Chambers et al. 1968, Ellinwood et al. 1966, McCord 1965; Wolk and Diskind 1961; Stanton 1979). In a study of female narcotic users, Johnston (1968) found that 65 percent had parents who had separated during their childhood. Cahalan (1970) reported that individuals who come from families that use and value alcohol and have a permissive attitude toward the use of other drugs are at high risk of becoming drug abusers. Binion (1979) also found that the family members of addicted women were more likely than families of nonaddicted women to have drinking problems. Often, a drug problem is symptomatic of complex family problems and may be a problem shared by other members of the family. Forty-three percent of the female drug clients in one study said that their partner is or was involved in drug dealing (Reed and Moise 1979). Corley (1978) concluded that, whenever possible, individuals who are part of the addict's supportive environment should be incorporated into the treatment program.

The importance of legal counseling services for female clients is also highlighted in the literature. Although a smaller percentage of women than men are referred to drug treatment programs by criminal justice agencies (13 percent and 23 percent, respectively), a relatively high percentage (39 percent) of the women report having been arrested within the 2-year period prior to admission (NIDA 1979). The sex difference in rate of referral may be partially due to the fact that women arrested for prostitution are less likely to be referred to treatment than other criminals. Reed and Leibson (1979) found that pressure from the criminal justice system had a profound influence on the treatment retention rates of female addicts. It has also been reported that female clients frequently

need legal help in attempts to get custody of their children (Densen-Gerber et al. 1972).

EMPLOYMENT

Employment represents yet another area in which women clearly require special treatment services and approaches. Employment rates among addicted women are extremely low. WDR data indicate that only 3 percent of female drug clients had been employed continuously (22 of 24 months) prior to admission and that 37 percent had no employment at all during the 2-year period prior to admission (Ryan 1979). Very little information is available in the literature on the kinds of vocational training programs that are being provided, or should be provided, to female drug abuse clients. There is a critical need for information on the number and types of training and job placement opportunities being offered to women in treatment.

In a study of vocational services provided to drug clients in Detroit, Edwards and Jackson (1975) found that there was a significant difference between the numbers of women (53 percent) and men (60 percent) referred for job placement. Among those referred for job placement, women were less likely to be hired than men. The 1979 CODAP data (NIDA 1979a) show that 79 percent of the female clients were unemployed upon discharge from treatment. It is therefore not surprising that women in drug treatment programs view employment and economic security as the primary elements of successful rehabilitation (Levy and Doyle 1977).

CHILD CARE

There is considerable evidence in the literature that a high percentage of women in treatment have dependent children. Eldred and Washington (1976) reported that 73 percent of the female addicts admitted to a city-run treatment program in Washington D.C., were mothers, and 48 percent of their children were under 6 years of age. Seventy-three percent of the drug-abusing women in the WDR study were mothers. They were more likely than comparison women to have children and less likely to be married. Colten (in press) found that 70 percent of the women in drug treatment have children and that 56 percent of these children live with their mothers. Similarly, in a study of female offender addicts, James (1979) reported that 67 percent had children. These data support the position that to be successful in treating female clients, programs should offer family services.

It was learned from the WDR study (Colten, in press) that drug-abusing women with small children must draw upon many different sources, including their extended families, to obtain the support they require in raising children. There are only a few drug

treatment programs that offer even nursery care for children during the period that their mothers are involved in treatment activities. Harris (1974) observed that women who are interested in receiving individual counseling and group therapy face the dilemma of what to do with their children. She describes the situation in which women who bring their children to treatment programs without child-care services are faced with constant interruptions and as a result, ineffective treatment. In a study designed to obtain female clients' views on the usefulness of different types of services, it was determined that half the clients (51 percent) felt that day-care services for their children would be of help (Sowder, in press). In another study designed to assess the needs of female drug clients, it was learned that approximately half of the women brought their children with them to the clinic at least some of the time (Wagner et al. 1977).

Numerous investigators, studying female addicts and their children, have documented the need for parenting services, including nursery care, counseling, and instruction in how to adequately fulfill the parent role for these children (Mondanaro 1976, Densen-Gerber and Rohrs 1973, Freedman and Finnegan 1976; Coppolillo 1975, Fanshel 1975, and Wilson et al. 1973). Colten (in press) found that drug-abusing women are perceived by others and by themselves as being less adequate than nonabusers as mothers. Mondanaro (1976) reported that female drug abusers have both cognitive limitations and affective needs and conflicts that impair their parenting ability. Cognitive limitations include not knowing how to care for their children and not knowing what to realistically expect from children at various ages. These difficulties and problems, as reported in the literature--in the areas of medical treatment, counseling, employment, and child-care services--point to a need for special treatment services for drug-abusing women. The following section attempts to explore the extent to which these special services are being provided in the treatment community.

CHAPTER 2

AN EXPLORATORY STUDY ON THE AVAILABILITY OF SERVICES

As a second approach to the study of drug-abusing women, an exploratory study was conducted by the authors to determine the services available to women in treatment programs. In designing the exploratory study the authors decided to focus on programs that make a special effort to serve women, rather than to obtain a sample of programs representative of the treatment field. This strategy was based on a review of findings from other research (Reed and Moise 1979; De Leon and Beschner 1977; Andersen 1977) that indicate traditional drug programs often do not have adequate resources to provide comprehensive services to women with drug problems. The study also represents a preliminary effort to locate facilities across the country that have explicit mandates to address the specific needs of women with drug problems.

METHODOLOGY

This study was conducted in the spring and summer of 1979. In the preliminary stages of the investigation there was an attempt to identify all of the drug agencies in the United States providing specialized treatment services to drug-abusing women.

Women-oriented drug programs were defined as those programs or program components having explicit policy and/or administrative mandates to address the range of special treatment needs of women in treatment. To be included in the survey, programs had to report themselves as attempting to make an effort to provide specialized services needed by drug-abusing women, such as specialized medical services, vocational training specifically oriented to women, specialized counseling for women, and child-care services. All of the participating programs had to be organized primarily to serve drug clients rather than alcoholics, although alcohol users and alcoholics could be included in the client populations.

The Single State Agency (SSA), the central coordinating organization within each State responsible for service delivery to drug abuse clients, is a logical source of information for identifying women-oriented drug treatment programs. Each of the 50 SSAs

was contacted and asked to identify drug treatment programs in their respective States that have explicit policy and/or administrative mandates to address the special treatment needs of drug-abusing women. Information collected about each program included a brief description of the treatment program and the name, address, and telephone number of a person to be contacted about the program (NIDA 1979b). State agencies that did not respond within 2 months were sent a followup letter again asking for the information. Of the 37 SSAs that responded to the survey, 30 identified programs that they thought were oriented to provide special drug treatment services to women, and 7 reported that there were no such programs in their States, 13 States failed to respond. The investigators used the snowball survey technique. Each of the agencies identified by the SSAs was contacted and asked to identify other drug programs that offered special treatment services to women. In all, 79 programs were identified.

To develop the data collection instrument, the drug research literature on treatment for drug-abusing women was used, as were suggestions from specialists in vocational rehabilitation, legal services, aftercare, medical treatment, and treatment of drug-abusing women. The questionnaire was modified after assessment by treatment experts in the drug field.

The final instrument was composed of 18 separate items including basic demographics (age, sex, and race), drug use questions, and a series of questions on the availability of various treatment services. The agencies were asked to provide data on those women in treatment during the 3-month period from October 1, 1978, to December 31, 1978. The majority of questions were closed-ended, requiring numerical responses that could be easily scored. The questionnaire was mailed to each of the 79 clinics identified, with a date given as to when phone calls would be made to collect the information. Data from the questionnaire were collected by telephone to minimize the possibility that clinics would fail to return the questionnaire and to provide an opportunity to clarify issues.

In surveying the 79 programs by telephone it was determined that only 44 met the selection criteria. Thirty-five programs were ineligible; of these, 22 did not offer specialized treatment services for women, 10 were exclusively alcohol programs, and 3 were no longer in operation. Of the 44 programs that met the criteria, 17 programs did not respond to a second mailing of the questionnaire sent after repeated efforts to obtain their cooperation, and 2 programs refused to complete the questionnaire because of staff shortages. In all, 25 programs were included in the study sample. While these 25 programs are undoubtedly an underrepresentation of drug programs serving women, it is reasonable to conclude that there are not many more such units. This conclusion is based on the extensive efforts made at the State and local levels to identify such programs and consultation with experts in the drug research field who are associated with women's programs. Given the limitations imposed by the approach used to locate the programs, this study must be viewed as exploratory.

Participating programs included 21 drug-free modalities and 4 methadone maintenance programs, as follows.

		Number of women
7	residential drug free serving only women	130
3	residential drug free serving men and women	42
3	outpatient drug free serving only women	49
8	outpatient drug free serving men and women	193
4	outpatient methadone maintenance serving men and women	133
	Total women in survey	547

STUDY POPULATION

As shown in table 1, most of the clients in the sample (86 percent) are 18 and over. Although black females make up only 16 percent of the clients served in the four drug-free modalities, this racial group represents 61 percent of the outpatient methadone maintenance client groups. Conversely, in the four drug-free modalities, whites constitute a disproportionate 78 percent of the clients.

As can be seen in table 2, just under half of the women in treatment reported that their primary drug of use at intake was either alcohol (24 percent), barbiturates (11 percent), or tranquilizers (11 percent).

The programs in our study serve women who seem to have different patterns of drug use than women typically treated in drug programs supported by the Federal Government. In particular, it is surprising to find that a relatively high percentage of women (24 percent) report themselves to be primary alcohol users compared to the much smaller percentage (5 percent) of women in CODAP[1] who reported themselves to be primary alcohol users during the same time period (October 1 to December 31, 1978). This finding may be explained by the fact that some of the programs are not supported by the National Institute on Drug Abuse and are therefore freer to admit primary alcohol users into treatment.

[1]The Client Oriented Data Acquisition Process (CODAP) is the client reporting system for all clients served by drug programs supported by the Federal Government.

TABLE 1.--Characteristics of women in treatment in women-oriented programs
October 1 - December 31, 1978

Client characteristics	Residential drug free, all F (N=130)		Residential drug free, M/F (N=4[illegible]		OP drug free, all F (N=49)		OP drug free M/F (N=193)		OP methadone maintenance M/F (N=133)		Total	
	N	Percent	N	Percent	N	Percent	N	Percent	N	Percent	(N=547)	Percent
Age												
Less than 18 years	27	20 8	4	9 5	3	6 1	41	21 2	1	0 8	76	13 9
18 to 25 years	76	58.4	20	47 6	17	34 7	44	22 8	64	48 1	221	40 4
26+ years	27	20.8	18	42 9	29	59 2	108	56	68	51 1	250	45 7
Race												
White	93	71.5	30	71 4	43	87 8	157	81 3	42	31 6	365	66 7
Black	32	24 6	12	28 6	2	4.1	20	10 4	81	60.9	147	26 9
Hispanic	3	2 3	0	0	2	4 1	9	4 7	10	7 5	24	4.4
Other	2	1.5	0	0	2	4 1	7	3.6	0	0	11	2

TABLE 2.--Primary drug problem of women in women-oriented programs
October 1 - December 31, 1978

Drug type	Residential drug free, all F	Residential drug free, M/F	OP drug free, all F	OP drug free, M/F	OP methadone maintenance, M/F	Total	Percentage
Opiates	25	12	3	18	131	189	34.6
Barbiturates	29	2	3	26	0	60	11
Amphetamines	5	3	1	16	0	25	4.6
Cocaine	2	2		3	0	7	1.3
Marijuana/ hashish	15	2	2	33	0	52	9.5
Hallucinogens	5	4	0	7	0	16	2 9
Inhalants	0	0	0	4	0	4	.7
Tranquilizers	10	7	13	26	2	58	10.6
PCP	1	2	0	0	0	3	.5
Alcohol	38	8	25	59	0	130	23.8
Total	130	42	[1]47	[2]192	133	544	99 5

[1]Does n t total 49 as the primary drug problem of 2 clients in this category is unknown
[2]Does not total 193 as the primary drug problem of 1 client in this category is unknown.

RESULTS

Medical Services

Table 3 presents data on the percentage of women who were provided specific types of medical services in each of the program categories.

For each medical service listed in table 3 there are two service delivery methods displayed: (1) treatment provided directly within the programs ("onsite"), and (2) treatment obtained for clients through referral sources. This distinction was made in order to gain some understanding of the medical resources contained within programs, the control programs have over specific units of medical services, and the extent to which programs procure services elsewhere.

As shown in table 3, 82 percent of the women in treatment received routine medical examinations, with slightly more than 50 percent having these services administered directly by the program. These statistics should be considered in light of the fact that all federally supported drug treatment programs are required to administer a general medical examination to all clients in treatment (Federal Funding Criteria for Drug Treatment Services Guidelines 1975).

Only the methadone maintenance programs provided all of their female clients with routine medical examinations. One reason for this difference is that FDA Methadone Regulations (Federal Register 1977) specify that methadone programs must maintain a minimum medical staff equivalent to 1 full-time licensed physician and 2 nurses for every 300 patients receiving methadone treatment. In addition, there must always be a medical or osteopathic physician available for initial medical evaluation, followup care, and supervision of patient medication schedules. All of the methadone programs in this survey reported having the capability of delivering these basic medical services within their own facilities. In comparison, only 63 percent of the female clients in outpatient drug-free programs serving men and women received routine medical examinations. The outpatient drug-free programs serving only women did provide medical examinations to 80 percent of their clients, with most of these services being obtained through referrals. With the exception of the methadone maintenance programs, the programs in our study did not have adequate professional medical resources within their own facilities.

Only 47 percent of the female drug clients were given gynecological examinations, 29 percent on site and 18 percent through referral. This seems to be a serious program limitation in view of the fact that there is evidence that drug-abusing women have a high incidence of gynecological problems (Andersen 1977).

These data (table 3) also indicate that other important medical services are limited in the study programs. Only 17 percent of the clients received dental examinations, and all of these services were

TABLE 3.--Medical services provided to women in treatment by women oriented programs
October 1 - December 31 1 78

Modality	Percent of women in treatment receiving														Percent whose children received medical examination	
	Routine medical examination		Gynecological examination		Eye examination		Neurological examination		Dental examination		Emergency medical services		Birth control			
	O	R	O	R	O	R	O	R	O	R	O	R	O	R	,	R
7 residential drug free, all F N=130	26 9	60	26 9	33 1	0	12 3	6 2	3 8	0	30 1	0	9 2	6	15 4	0	2 3
3 residential drug free, M/F N=42	26 2	73 8	0	54 8	0	11 9	0	0	0	57 1	0	26 2	0	57 1	0	0
3 OP drug free, all F N=49	0	79 6	0	38 8	0	0	0	0	0	0	0	0	0	38 8	0	0
8 OP drug free, M/F N=193	56 5	6 2	0	6 2	0	0	0	0	0	0	0	0	0	(	0	0
4 OP methadone maintenance, M/F N=133	100	0	91 7	0	0	3	0	2 3	0	22 6	13 5	4 5	52 6	4 5	51 1	9
Percent	52 8	29 3	28 7	17 7	0	4 6	1 5	1 5	0	17 2	3 3	5 3	12 8	13	1. 4	2 2
Total N=547	(289)	(160)	(157)	(97)	(0)	(25)	(8)	(8)	(0)	(94)	(18)	(29)	(70)	(71)	(61)	(12)

O - Onsite
R - Referral

obtained through referral. Birth control services are important to women, yet only a quarter of the women in our study were given information on birth control, and approximately half of these women received the information from two of the methadone programs included in the study. None of the drug-free modalities provided birth control services within their facilities.

Relatively small percentages of clients received such ancillary medical services as eye examinations (5 percent) and neurological examinations (3 percent). It was learned that 9 percent of the clients received emergency medical services, but it is difficult to assess these services without more information about the nature of the problems experienced.

Only 3 of the 25 programs provided medical examinations for the children of clients; 2 of these were methadone maintenance programs, and the third was a residential drug-free program.

An overall assessment of medical services by environment/modality shows the outpatient drug-free programs provide far fewer services than the other modalities included in this study.

Counseling Services

As expected, most of the clients (91 percent) were given basic drug counseling services. (See table 4.) It is noteworthy that these drug programs also delivered alcohol counseling to 45 percent of the clients. As indicated earlier, a significant number of the clients treated in the women-oriented drug programs (24 percent) reported that alcohol was their primary drug of abuse.

More than half of the clients (58 percent) received psychological counseling (distinguished from drug counseling or alcohol counseling by being defined as counseling services oriented to helping clients address and cope with their underlying psychological problems). Such services could be delivered by professionals or paraprofessionals. The lowest rate of psychological counseling (12 percent) occurred in outpatient drug-free programs for both men and women, while the highest (100 percent) was in outpatient drug-free programs for women only. This suggests either that all-women outpatient drug-free programs recognize the need for psychological services for women or that women who want psychological counseling are more inclined to seek these services from all-women programs.

The data presented in table 4 show that approximately half of the clients received some form of family counseling. Evidently programs serving women do recognize the importance of providing family services and do, in fact, deploy resources in this area. The modalities that serve only women seem to put more emphasis on this service.

TABLE 4.--Percentage of women receiving counseling services provided by women-oriented programs October 1 - December 31, 1978

	Drug	Psycho-logical	Family	Alcohol	Feminist	Sex	Nutri-tion	Parent-ing	Finan-cial	Legal
7 residential drug free, all F N=130	100	87.7	79.2	61.5	79.2	57.7	54.6	31.5	65.4	12.3
3 residential drug free, M/F N=42	69	81.8	21.4	14.3	31	21.4	4.8	0	4.8	7.1
3 OP drug free, all F N=49	79.6	100	61.2	67 3	79 '	61.2	61.2	10.2	0	65.3
8 OP drug free, M/F N=193	99	11.9	38.3	58	4.7	2.6	.5	1.6	.5	2.1
4 OP methadone maintenance, M/F N=133	81.2	71.4	43.6	12	5.3	20.3	26.3	63.9	26 3	3.7
Percent	90.9	57.6	50.1	45.2	31.3	26.7	25.4	24.3	22.5	11
Total N=547	(497)	(315)	(274)	(247)	(171)	(146)	(139)	(133)	(123)	(60)

As might be expected, relatively large numbers of clients in the two all-female modalities (four out of five clients) received feminist counseling and sex counseling (three out of five clients). In addition, 65 percent of the all-female outpatient drug-free clients were given legal counseling. In comparison, the three modalities serving both men and women did not provide many clients with these important services. As can be seen in table 4, less than 1 percent of the clients in outpatient drug-free programs serving men and women received either nutritional or financial counseling, only 3 percent sex counseling, and 2 percent legal counseling.

Parenting counseling services were delivered to 24 percent of the total sample of clients. Although this would seem to be a reasonable figure for all sampled programs, the figure is misleading since two of the methadone programs with parenting components provided these services to all their clients, accounting for more than half of the clients who receive counseling in parenting.

Employment/Education Services

The programs in this study assessed the vocational skills of 36 percent of the clients in treatment. (See table 5.) Vocational counseling was provided to 34 percent of the clients, and 11 percent received job skills training. These numbers seem small in view of the apparent degree of need for employment services. Job development services were provided to only 12 percent of the clients while 18 percent received help with job placement. Certainly, more investigation is needed in this area to determine why programs do not attempt to provide more employment services. The findings may reflect particular limitations that the programs have, such as funding insufficient to provide these services. Alternately, they may reflect a lack of employment opportunity, the inability of clients to utilize services, or a combination of these and other factors. For example, clients with dependent children may be unable to assume full-time jobs, and some clients may prefer the role of homemaker.

One-third of all the clients in the programs acquired education counseling, and 18 percent received education placements. Only small percentages of clients in the two outpatient treatment modalities serving both men and women received employment and education services. The residential modalities, which provided these services to the highest percentages of clients, evidently have more time to work with clients who are in residence, and have the staff capability to provide employment and education services. The outpatient drug-free programs serving only women provided skills assessment, vocational counseling, and education counseling services to more than half their clients--considerably more than the outpatient drug-free programs serving both males and females.

TABLE 5.--Percentage of women receiving employment/education services provided by women-oriented programs October 1 - December 31, 1978

Modality	Vocational skills assessment	Vocational counseling	Employment training	Job placement	Job development	Education counseling	Education placement
7 residential drug free, all F N=130	73.1	63.1	23.8	28.5	26.9	71.5	49 2
3 residential drug free, M/F N=42	97 6	90.5	42.9	57.1	42.9	88.1	26 2
3 OP drug free, all F N=49	51	51	20.4	10 2	10 2	57.1	4.1
8 OP drug free, M/F N=193	9.8	9 8	.5	1	2 6	6 7	0
4 OP methadone maintenance, M/F N=133	12 8	14.3	0	22 6	1 5	8 3	14 3
Percent	36	33 5	11	17 9	11 9	33.3	17.6
Total N=547	(197)	(183)	(60)	(98)	(65)	(182)	(96)

Child-Care Services

It can be seen from the data in table 6 that only a small number of children were provided day care, medical examinations, recreation, education, and/or foster parent referral services. (The percentages of children served cannot be derived since there was no attempt in this study to determine the total number of dependent children.)

Only 40 children received day-care services in the 25 programs, and 13 of these children were served in 1 program, which has since been discontinued. Eighty-three children were given medical examinations; all but three examinations were provided by two methadone maintenance programs structured to serve addicted women and their children. Recreational services were delivered to 23 children of clients served in residential programs, and education services were given to 30 children.

SUMMARY AND CONCLUSIONS

There is evidence presented in the literature that drug-abusing women entering treatment are likely to present chronic medical and complicated psychosocial problems that require special attention from those agencies attempting to serve them. Investigators have documented the need for comprehensive medical and health-related services, including female-oriented medical examinations and followup, and dental, nutritional, and birth control services.

Compared to male drug abusers, drug-abusing women have higher levels of personal distress (depression, anxiety, etc.) and lower levels of self-esteem, thus indicating the need for special counseling and support services. In addition, programs must be sensitive to the fact that drug-abusing women are likely to be mothers responsible for dependent children. Programs must not only consider the need for parenting and child-care services, but also must consider how responsibility for dependent children may impact on the ability of women to participate in a treatment process. Treatment services such as employment counseling and job placement will often need to be modified in view of the drug-abusing mother's unique circumstances.

The exploratory investigation conducted by the authors on 25 programs that make a special effort to serve women shows that most of the 547 women in the study did receive basic drug treatment services, i.e., routine medical examination and drug counseling. About half were given services such as psychological and family counseling, and approximately one-third received skills assessments and education counseling. However, given what has been learned about the treatment needs of drug-abusing women and the avowed orientation of the programs sampled, it was surprising to find that large percentages of women clients had not received other essential medical services such as gynecological examinations (54 percent), birth control counseling (74 percent), dental care (83 percent),

TABLE 6.--Services provided to children of women in treatment by women-oriented programs[1]
October 1 - December 31, 1978

	N	Day care	Medical examination	Recreation	Education	Foster parent
Residential drug free, all F	130	2	3	4	0	0
Residential drug free, M/F	42	15	0	19	0	0
OP drug free, all F	49	19	0	0	3	0
OP drug free, M/F	193	4	0	0	0	0
OP methadone maintenance, M/F	133	0	80	0	27	3
Totals	547	40	83	23	30	3

[1]This table provides data on the number of children served. Some clients had more than one child served.

and ophthalmological examinations (95 percent). In addition, most clients did not receive vocational counseling (67 percent), job placement services (82 percent), and educational placement services (82 percent). Other than methadone programs, which did provide medical examinations and educational services for children of clients, it appeared that few programs were making an attempt to serve the children of female clients.

There were significant differences in services delivered by type of program. For example, residential programs (both co-sex and all female) were much more likely to provide vocational and educational services than outpatient programs. Outpatient co-sex programs were the least likely to provide the vocational and counseling services that are oriented to help women function independently. Programs serving only women had larger percentages of clients involved in feminist, sex, nutritional, and family counseling than co-sex programs.

In conducting the study, only 25 programs serving 547 women were located after a concerted effort to identify programs concerned with the provision of services to women. It thus appears that these programs are few in number and limited in scope.

The reasons for which these women-oriented programs are limited in number and comprehensiveness of services are unclear. However, it is likely that many of these programs do not have the financial and staff resources necessary to establish the full range of services needed by the clients. It is also possible that programs do not have the technical knowledge and capability to implement and deliver the required services. The possibility must also be raised that drug programs may not have the interest or desire to provide the comprehensive services needed by women.

In addition, the findings suggest that since the resources needed by drug-abusing women are obviously scarce, drug programs designed to serve women must make a more concerted effort to identify and utilize existing community resources. These, of course, are not easy tasks. Programs that are interested in helping women clients acquire needed resources in the community must be prepared to invest in an advocacy role. This investment will require staff time, patience, and understanding--the capacity to search out available resources, the desire to motivate clients to become more self-reliant, and the willingness to challenge existing institutions and systems.

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