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ABSTRACT

Historically, women's problematic substance use has been largely ignored. For women to consume alcohol on anything but a restricted social basis, let alone have a substance use problem, did not fit into the stereotypes. Many programs that have been developed to deal with problematic substance use, have been developed from a solely male perspective. Service providers, policy makers, and women seeking services all need to be cognizant of these barriers. A major barrier that women currently face in Saskatchewan is the lack of women-only treatment and continuing care programs that acknowledge and address the social, cultural, and economic realities of their lives. This report, Phase Two of what is designed to be a three phase project, expands on and confirms the initial assessment of needs determined in Phase One. A survey to assess current services was conducted with Saskatchewan agencies who work with women and the issue of substance use. As well, women who have sought treatment and/or continuing care were interviewed. Their experiences can provide critical insight into where changes need to be made. Recommendations for treatment of problematic substance use are given. (BF)

THE MANY VOICES OF WOMEN & SUBSTANCE USE

by

Women's Action Committee on Substance Use

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The views expressed herein are solely those of the authors and do not necessarily represent the official policy of Health & Welfare Canada.

EXECUTIVE SUMMARY

Historically, women's problematic substance use has been largely ignored. For women to consume alcohol on anything but a restricted social basis, let alone have a substance use problem, did not fit into the stereotypes (Clark, 1990). Many programs that have been developed to deal with problematic substance use, have been developed from solely a male perspective (Sandmaier, 1977). Service providers, policy makers and women seeking services alike, need to be cognizant of these barriers. A major barrier that women currently face in Saskatchewan is the lack of women-only treatment and continuing care programs that acknowledge and address the social, cultural and economic realities of their lives.

The Project

This report is Phase Two of what is designed to be a three phase project. Funding has been provided by the Community Action Program of Canada's Drug Strategy, Health & Welfare Canada. The initial grant was given to what was then called the Advisory Committee on Women and Substance Use, and administered through University Extension, University of Regina.

The Many Faces of Women and Substance Use

Phase I, The Many Faces of Women and Substance Use, examined and identified the needs and issues of women at risk by conducting a review of current literature and holding community consultation sessions. The goal was to assess needs, increase awareness and stimulate community participation and action regarding women's problematic substance use. Phase I identified the following needs:

- gender specific (women orientated) support groups and treatment services;
- programming which addresses sexual abuse and domestic violence issues;
- services which recognize the unique social, cultural and economic realities of all women (including older women, lesbian and bisexual women, Aboriginal women, women of colour, and women with disabilities).; and
- services which provide a safe environment for women to come together to discuss the issue of women's problematic substance use, an environment which is non-shaming where women will feel free to discuss their experiences.

The Many Voices of Women and Substance Use

Phase II, The Many Voices of Women and Substance Use, expands on and confirms this initial assessment of needs. A survey to assess current services was conducted with Saskatchewan agencies who work with women and the issue of substance use. As well, women who have sought treatment

and/or continuing care were interviewed. Their experiences provide critical insight into where changes need to be made.

The majority of women interviewed reported abuse (emotional, physical and/or sexual) as being a contributing factor to their problematic substance use. They indicated the desire to have recovery programs that would address the issue of abuse. Agency respondents strongly agreed that further programming in this area needs to be developed.

Many women also indicated that they felt recovery programs were inaccessible in either an economic or cultural way. Lesbian and bisexual women pointed to the heterosexism and homophobia that silences their life experiences while in recovery. Women also cited the difficulty in arranging childcare and meeting other financial needs prior to seeking treatment.

Recovery programs were often inaccessible from a number of perspectives. In some cases women who reported physical disabilities had difficulty simply accessing the building that housed continuing care programs. In other instances women pointed to the lack of access to services and materials in their first language, and that often the literacy level used in resource materials was inappropriate. Finally, systemic racism and oppression presented a major barrier to Aboriginal women and women of colour, who often found themselves overrepresented as recovery service users and underrepresented as recovery service providers.

Most agency respondents indicated that they supported increased programming in the above mentioned areas in order to reduce barriers that many women are faced with when seeking recovery.

Recommendations

Based on the interviews with women and the agency responses, this report recommends the following:

* **That services for problematic substance users must meet the needs of women seeking recovery.**

* **That professionals, service providers and policy makers receive training and education on abuse issues and gender equity, cross cultural training and updates in other areas of current research on women and problematic substance use.**

* **That gender and cultural sensitivity and sensitivity to abuse issues be central in substance use recovery programs.**

* **That women-only and Aboriginal-specific recovery services be developed and made available.**

* That childcare must be made available for women throughout recovery.

* That services must reflect the varied literacy levels of clientele.

* That a newsletter initiative, including contributions from Saskatchewan women, be explored.

* That a coalition of service providers and women who have sought services be formed to provide direction for updating and developing policy.

* That continued public information must include the special needs of women in substance use recovery programs.

* That research for, by and about women be continued and reflect the province's diverse population.

* That the promotion and protection of the overall well-being of women be maintained as an ultimate goal.

* That women be invited and encouraged to actively participate in the development and evaluation of programs and related policies that pertain to substance use recovery for women.

Increasing awareness of issues related to problematic substance use is of critical importance for women. Firstly, it encourages the development of programming that acknowledges and addresses the unique needs of women. As well, increased public awareness creates a dialogue, acting as a catalyst for prevention strategies that focus not only on substance use, but the underlying power issues that are contributing factors.

CONTENTS

ACKNOWLEDGEMENTS

We recognize and appreciate the Saskatchewan women who shared their life experiences, creating a report that gives a voice to their varied and diverse stories. We thank those agencies who participated in our survey of agency services. We also recognize the assistance of staff at University Extension, particularly Della Allen, Dan Beveridge, Marcia Wickenheiser, and special thanks to all the women of the Women's Action Committee on Substance Use, especially the editorial committee. We acknowledge the important assistance of our project staff: Susan Swedberg-Kohli, Cora Gardiner, for helping us gain access to the northern part of the province, and especially Colleen Taylor for her dedication, skills, thoughtfulness and long hours. Finally, we acknowledge the support of this project by Canada's Drug Strategy, Health & Welfare Canada.

- Women's Action Commitee on Substance Use
  Regina, Saskatchewan November, 1993

PREAMBLE

The Women's Action Committee on Substance Use believes in equality with respect to gender, race, sexual orientation, ability, and ethnic background. Our mission is to uphold these principles by promoting and developing anti-sexist, anti-racist, anti-homophobic and anti-classist services for women with problematic substance use.

In 1991, with the support of Canada's Drug Strategy, Health & Welfare Canada, we compiled our first report, The Many Faces of Women and Substance Use. We now provide this new report, The Many Voices of Women and Substance Use, which supports the need for special programming and advocates on behalf of women. This new report listens to, affirms and responds to the voices of Saskatchewan women who have experienced problematic substance use.

The women who participated in our survey courageously described their experiences, identified forces which impact upon their recovery and discussed the strengths and gaps in recovery processes with which they are or have been involved. We have also surveyed service providers in Saskatchewan and present their responses related to the needs of women. In addition, we have created a guide for women who need to access services, a guide which will assist women to determine where and how to access gender-relevant help.

We believe that women's voices must be heard and acknowledged, that it is women's voices which need to steer policy decisions and continued development of relevant services for women.

We offer this report as a road map for policy makers and service providers as we all work towards effectively meeting the needs of Saskatchewan women who experience problematic substance use.

Jean Esson
Women's Action Committee on Substance Use

DEFINITIONS

For the purposes of this report the terms below have been defined as follows:

Accessibility:
Refers to access in its broadest perspective - meeting the unique individual needs of **all** women. This includes access for those living with disabilities, access to resource materials specific to varied literacy levels, access to services in a client's first language, as well as access to further technical and medical support.

Continuing Care:
This refers to all forms of recovery after treatment including but not limited to counselling and support groups.

North:
Refers to all areas in Saskatchewan north of Prince Albert with the exception of Meadow Lake, which is included as rural.

Rural:
Refers to all areas of Saskatchewan south of Prince Albert which are not considered urban areas.

Saskatchewan Alcohol and Drug Abuse Commission (SADAC):
On August 1, 1993 SADAC was disestablished and is now known as Alcohol and Drug Services, Saskatchewan Health. Throughout the report the agency is referred to under its former name, SADAC.

Treatment:
This term refers to all in-patient and out-patient centres and halfway houses.

Urban:
Refers to all Saskatchewan cities as defined by Census Canada.

Women's Action Committee on Substance Use (WACSU):
In December of 1993, the Provincial Advisory Committee on Women and Substance Use changed its name to the Womens Action Committee on Substance Use.

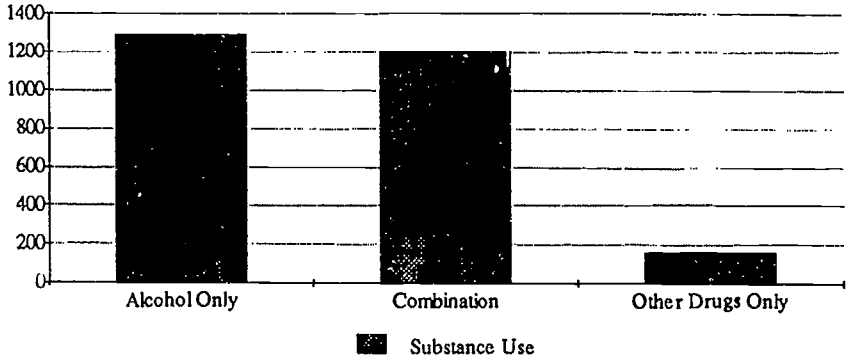
INTRODUCTION

According to preliminary statistics provided by the Saskatchewan Alcohol and Drug Abuse Commission, in the 1992/93 fiscal year, there were 2653 women in treatment for chemical dependency (SADAC, October 1993). Figure 1 provides a breakdown of the types of problematic substance use.

FIGURE 1

WOMEN IN TREATMENT

Source: SADAC



This represents a 3.8% increase as compared to the 1991/92 fiscal year when 2532 women used SADAC treatment services (SADAC, April, 1993). Women make up about 30% of all clients as they have for the past five years. This figure alone does not necessarily reflect the number of women who are seeking help for problems related to substance use. An American study found that women were overrepresented in the mental and primary health services while men were overrepresented in treatment services. "The researchers attributed this disparity to the "unique barriers" women face in getting treatment for alcoholism: financial limitations, inaccessibility of child care and social stigma" (The Addictions Letter, February 1993, p. 4). Women who pursue treatment and continuing care programs often face a field developed for and dominated by men (Peluso & Peluso, 1988).

In Saskatchewan, women have no women-only treatment centres and continuing care programs. While Saskatchewan has one women-only treatment program within a co-ed environment (Calder Centre), its Western sister provinces have several women-only centres; 16 programs in British Columbia and 9 programs in both Alberta and Manitoba (Lightfoot et al, 1992). Although Saskatchewan has a smaller population base than the other three Western provinces, it is unlikely that the province's one women-only treatment program is meeting the demand for women-only programming. As the demands for treatment and continuing care for women increase, so too does the need to examine the adequacy of resources currently available for women and the many barriers to recovery that women face.

1. Project Summary

This report is Phase II of a three-phase project designed to increase awareness and to stimulate community participation and action regarding women's problematic substance use.

Phase I, "The Many Faces of Women and Substance Use", was concerned primarily with identifying the needs and issues of women who are at risk.

The intent of Phase II, "The Many Voices of Women and Substance Use", is to extend and confirm the findings of Phase I. This is achieved by producing a preliminary assessment of existing resources, programs and services for women who are at risk of harm due to their substance use in the context of the socio-economic-cultural reality. This assessment asks the question, "How adequately served are Saskatchewan women needing help with substance use?" and "How successful are service agencies in meeting women's needs?" Response to these questions are provided by both the providers of the services and the women who access these services.

Pending approval of funding, Phase III will be a community and professional awareness phase. It will include the development of workshops with accompanying resource packages delivered throughout the province.

2. Background

In March of 1991, University Extension, University of Regina began the project, "The Many Faces of Women and Substance Use", funded by a grant from the Community Action Program of Canada's Drug Strategy, Health & Welfare Canada. The aims of this project were to identify women's perceptions of their own needs vis-a-vis problematic substance use, to increase community and professional awareness and to stimulate action in response to problematic substance use by women.

The project consisted of a literature review and a needs assessment. It was primarily concerned with identifying needs and issues of women who were at risk. (see The Many Faces of Women and Substance Use, Final Report, 1991 and Summary Report, 1991).

A provincial advisory committee was formed to guide the project, to assist in organizing three needs assessment community consultations in October of 1991, and to hold a news conference in May of 1992. This ten member committee represented a wide variety of organizations and interests with representations from Regina, Saskatoon and Prince Albert who worked in health services, mental health, corrections, addictions and other areas. Conclusions emerging from this needs assessment identified the following needs:

- gender-specific (women orientated) support groups and treatment services;

- programming which addresses sexual abuse and domestic violence issues;
- services which recognize the unique social, cultural and economic realities of all women (including older women, lesbian and bisexual women, Aboriginal women, women of colour, and women with disabilities); and
- services which provide a safe environment for women to come together to discuss the issue of women's problematic substance use, an environment which is non-shaming where women will feel free to discuss their experiences.

In the fall of 1992 the provincial advisory committee in conjunction with University Extension submitted a proposal and received funding for Phase II of the project which was carried out from March to October of 1993. Members of the Advisory Committee are:

Donna Benesh	SADAC
Dan Beveridge	University Extension
Kathy Donovan	SADAC
Jean Esson	Saskatchewan Teacher's Federation
Gloria Geller	Social Administration Research Unit, University of Regina
Priscilla Joseph	Prince Albert Cooperative Health Clinic
Ramona Larrio	NNADAP
Sheri McConnell	Committee Chair
Liz McQuarrie	YWCA Isobel Johnson Centre, Regina
Annette Neustaedter	Pine Grove Correctional Centre, Prince Albert
Pat Robinson	Regina Women's Community Centre

3. Literature Review Findings

A literature review (Goettler and Pearce, 1991) was conducted in Phase I to identify prevailing patterns, themes and issues relating to substance use among women. Little research has been done on the issue of women and substance use. Sexual abuse, depression, low self-esteem, stress and substance use within the family are significant factors contributing to problematic substance use. Sexual dysfunction, sexual behaviour and sexual orientation also affect and are affected by women's use of substances.

The review examined barriers to treatment including availability of treatment, and discrimination and harassment while in treatment. The relationship of these barriers to recovery and continuing care was explored.

It was recommended that awareness of women's needs related to substance use be increased, particularly for the service provider.

4. Methodology

In March of 1993, a survey of agencies to determine the level of services and attitudes regarding services for women, was distributed to 133 agencies (see Appendix 1 for listing). Following a letter from the SADAC Acting Executive Director, 48 questionnaires were sent to SADAC regional offices and funded agencies; 68 were handed out to NNADAP (National Native Alcohol and Drug Abuse Program) co-ordinators at a provincial meeting; and 17 were sent to other agencies (see Appendix 2 for survey questionnaire). Self-addressed stamped envelopes were provided. In fall of 1993, 105 agencies were contacted again, to encourage the return of their questionnaires. Another 14 responses were received, for a total of 42 returned.

Advertisements were placed in approximately 100 Saskatchewan weekly newspapers and a notice was placed in the Women's Mental Health Agenda Project Newsletter, inviting women, who currently or in the past have experienced problems with substance use, to participate in a survey of women's needs. In addition, a letter was sent to 100 affiliate agencies (i.e. not specifically addiction services agencies) with the same request. Women who responded to the request were contacted by mail or phone to arrange interview times. In September, letters were sent out to service providers and community contacts in hopes of increasing the number of potential interviews. Word of mouth was also effective in garnering responses. All 29 persons who were successfully contacted and willing to participate were interviewed.

FINDINGS

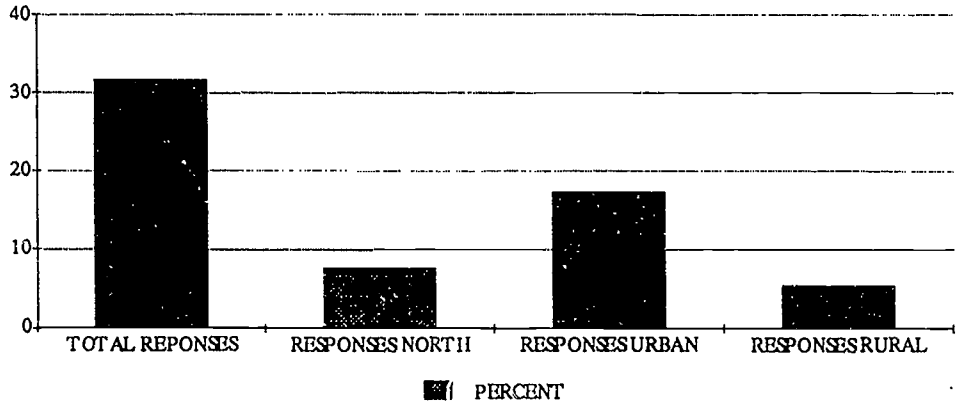
The Agencies

Of a total of 133 questionnaires distributed, 42 were returned giving a response rate of approximately 32%. Figure 2 illustrates the percent of responses by geographic area.

FIGURE 2

PERCENTAGE OF AGENCY RESPONSE

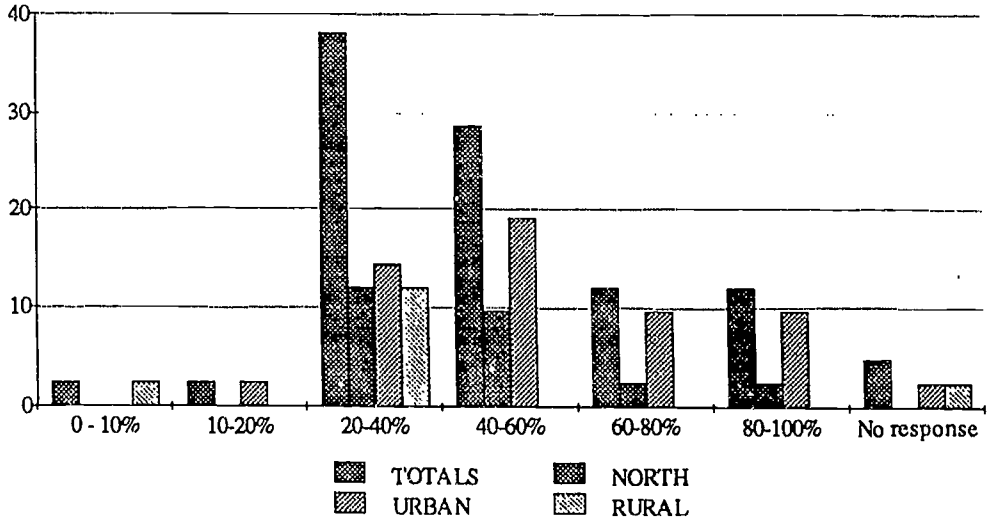
BY REGION



Agencies were asked to identify the percentage of their clientele who are women. As indicated in Figure 3, the majority of agencies responded that their clientele is between 20 to 40 percent women, a figure consistent with the data provided by SADAC.

FIGURE 3

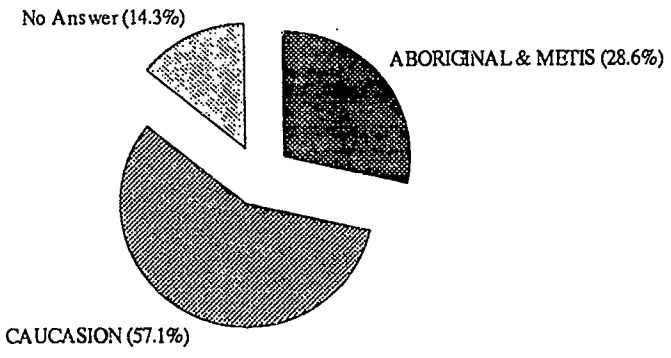
WOMEN AS PERCENT OF TOTAL CLIENTELE



The Women

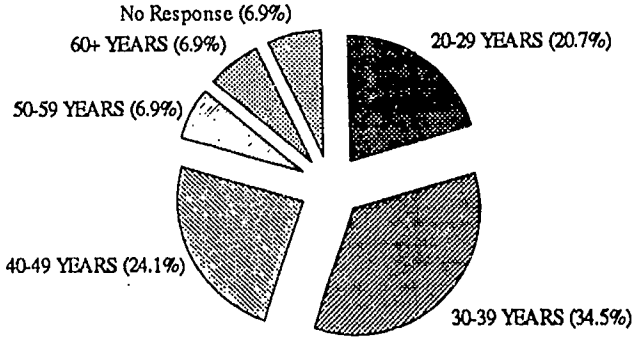
A total of 29 women's stories were included. The majority of women were interviewed in a face-to-face setting, some by phone, and some by mail. The story of a woman who had committed suicide was told by her son. As shown in Figure 4, 28.6% of women were of Aboriginal or Metis ancestry.

FIGURE 4
RACIAL BACKGROUND OF WOMEN



The majority of women interviewed were between the ages of 30 to 39 years old as indicated in Figure 5.

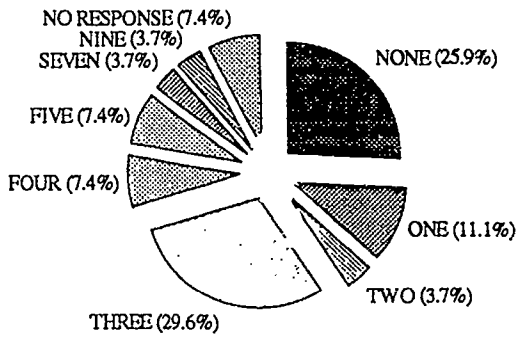
FIGURE 5
AGE CATEGORIES OF WOMEN



Of this sample, 8% of women reported a disability. Twenty-five percent of women identified as lesbian or bisexual. The majority of women had children, ranging from one to nine children. 26% of women reported that they had no children (See Figure 6).

FIGURE 6

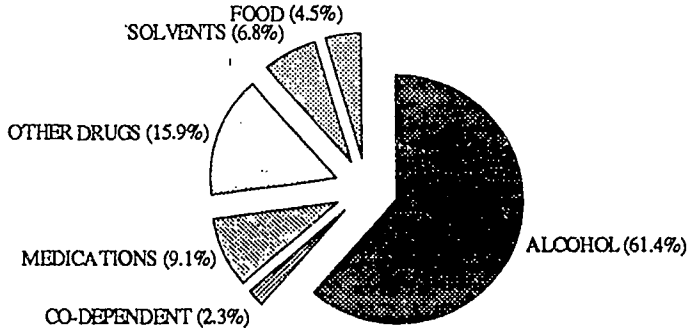
NUMBER OF CHILDREN



The women interviewed identified a number of substances, the use of which had become problematic. As indicated in Figure 7, alcohol was the most common substance, with 61.4% of women indicating problematic use.

FIGURE 7

TYPES OF PROBLEMATIC SUBSTANCE USE



During the course of the interviews, women identified many issues that affected their problematic substance use and their recovery including:

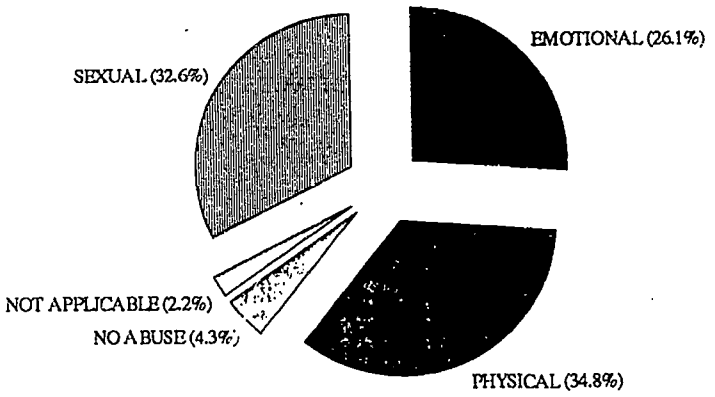
- sexual, physical and emotional abuse
- sexual orientation
- lack of access to childcare
- limited financial resources
- lack of cultural sensitivity
- issues regarding continuing care.

The vast majority of women surveyed reported abuse or involvement in abusive relationships. Many indicated that they had experienced more than one type of abuse. Figure 8 shows the types of abuse encountered by the women surveyed. In a recent study,

Justice For Women Victims & Survivors of Abuse, Gloria Geller discovered that many women who are survivors of abuse often will turn to substance use as a means of coping (Geller, 1991). Of the 26 women interviewed who reported abuse, most cited alcohol and other drugs as a coping mechanism to deal with the shame and the pain.

FIGURE 8

TYPES OF ABUSE REPORTED



1. Domestic Violence

Physical abuse comprised 35% of the incidents of abuse as reported by the women surveyed (see Figure 8). They indicated that dealing with physical abuse made it extremely difficult to relate to other male clientele and, in many cases, male counsellors, during treatment and continuing care.

There is a great deal of shame related to domestic violence. Often women believe their abusers and feel that they are in some way responsible for the abuse that they suffer (NiCarthy, 1987). One woman who spoke about getting beaten by her male partner, stated that she couldn't really blame him for the abuse because he was frustrated with her always being intoxicated. Often women identified their partners as addicted or in recovery. In cases where both partners were using substances, abuse was always present. Substance use became a way of coping with an abusive relationship. As one woman expressed it:

> ***I drank to numb the pain and hurting inside. I knew the abuse would not hurt as bad if I was drunk!***

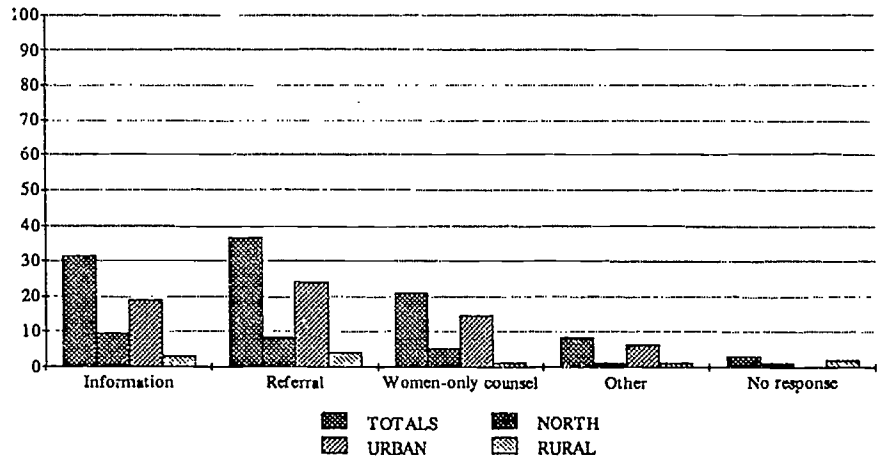
For women in recovery, continuing abuse interfered with their recovery process. One woman recalled phoning A.A. for assistance and then refused to let people into her home to "12-step" her for fear of her husband's reaction. She stated that:

If I could get beat for doing homework, what would happen if strangers came to my home? I didn't want people to know what was going on in my home.

The ability of agencies to deal with the issue of domestic violence varied. Figure 9 shows the response of agencies to the question highlighted above it, indicating referral as the most common programming response.

Do you provide programming to address the issues of family violence?

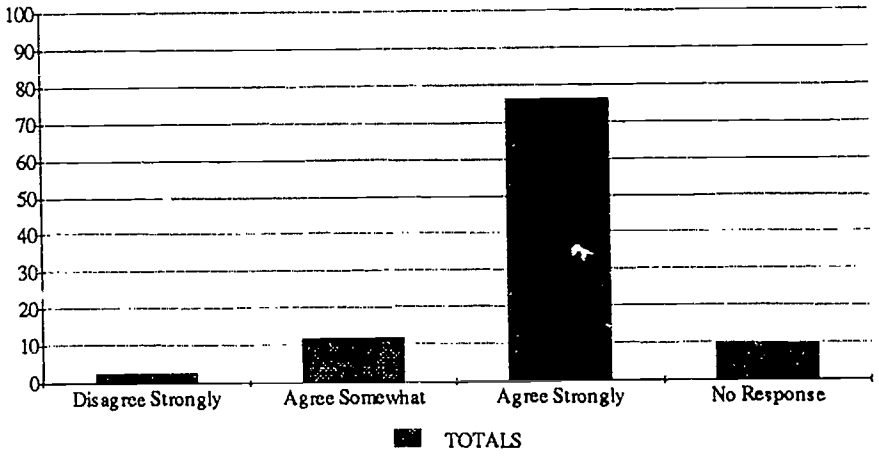
FIGURE 9
AGENCY SERVICES - DOMESTIC VIOLENCE



As shown in Figure 10, responses from agencies strongly reflect the need for programming responsive to domestic violence for women in treatment and continuing care. Breaking the silence of domestic violence is seen as critical. It was noted that women who acknowledge domestic violence also have a better chance of coming to terms with their own problematic substance use. (The study referred to is our Phase I Needs Assessment).

The study recommends that programs need to address women's needs as they relate to family violence. What do you think - and why?

FIGURE 10
AGENCY ATTITUDES TOWARDS
INCREASED PROGRAMMING FOR FAMILY VIOLENCE



2. Sexual Abuse

As Figure 8 indicates, almost 33% of reported incidents of abuse involved sexual abuse (incest, rape or molestation). In Phase I of the project, sexual abuse was identified as a potential antecedent predisposing women to alcoholism (Goettler & Pearce, 1991). As well, many women indicated that as a result of sexual abuse they had difficulty trusting others, particularly men. This inability to trust others affected their ability to seek and actively participate in addiction treatment and continuing care. Many of the women interviewed indicated that support for dealing with sexual abuse issues was garnered by contacting outside agencies. Many reported that treatment and continuing care programs were not responsive to the issue of sexual abuse. One woman interviewed echoed the sentiments of many women, saying:

> ***It was difficult sharing the pain about being abused and that wasn't addressed in treatment.***

Women who identified as survivors of sexual abuse rarely disclosed to counsellors while in treatment, nor did they discuss it in the groups that they joined as part of their continuing care. The shame that kept them silent presented a major barrier to self-acceptance, often leading to destructive behaviour patterns, whether or not they were in recovery.

> ***I feel if someone would have taken me and said, "You need some professional help", and steered me in the right direction, I wouldn't have been in pain for so long. Looking back I was very depressed. I didn't recognize it and neither did others. I was always trying to get rid of me - jumping off fire escapes - I just wanted to get rid of the pain.***

Another woman spoke of the isolation due in part to the inability to deal with her abuse issues while in detox and later in continuing care.

> ***I was reaching out and nobody was accepting of what I was reaching for. I knew alcohol and drugs were a problem. I knew that. But there were other things that made alcohol and drugs easy to reach for as a crutch to deal with it.***

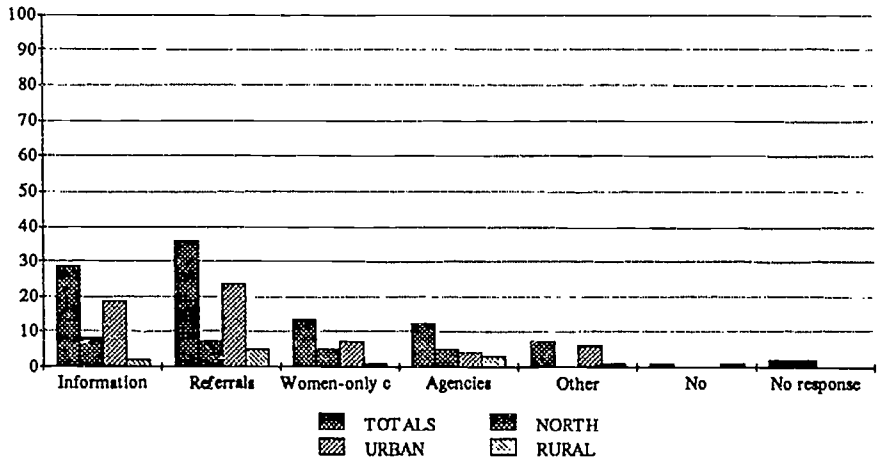
The need for organizations to help survivors deal with sexual abuse issues is critical. One woman active in Alcoholics Anonymous (A.A.) in an urban centre commented that:

> ***I haven't met any woman in the program who hasn't been sexually abused.***

The ability of agencies to address the issue of sexual abuse varied (see Figure 11).

Do you provide programming addressing the issue of the sexual abuse a woman may have experienced as an adult or a child?

FIGURE 11
AGENCY SERVICES - SEXUAL ABUSE



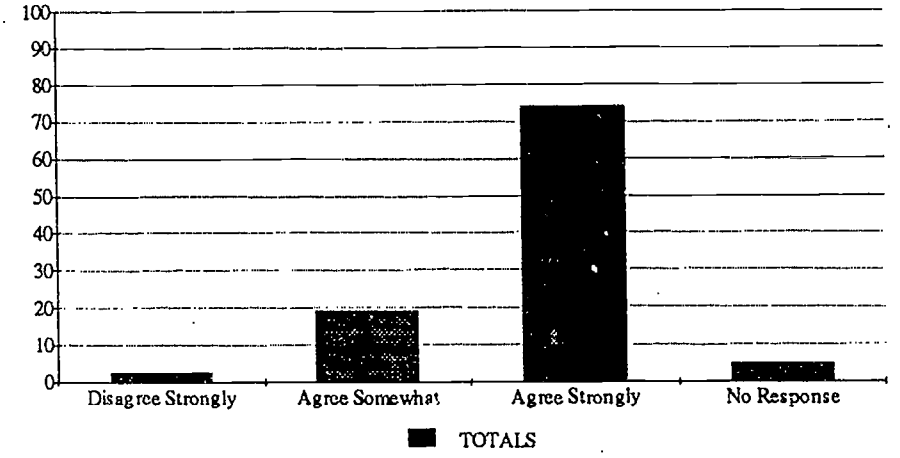
Currently, services by addiction agencies largely consist of referral to outside agencies. About 28% of agencies reported having information about sexual abuse issues. Only 12.3% of agencies included resources from outside agencies in their programming. In the agency survey of attitudes towards the issue of sexual abuse, most recognized the extent of the problem as it relates to substance use. In the words of one respondent:

> ***We are all aware of women who attend numerous treatment programs without success until they start healing from sexual abuse.***

As shown in Figure 12, 77.5% of respondents **strongly agreed** that there needs to be programs that address the issues of women and sexual abuse in treatment and continuing care.

The study recommends that programs need to address the issues concerning women who have been sexually abused, as adults or children. What do you think - and why?

FIGURE 12
AGENCY ATTITUDES TOWARDS INCREASED PROGRAMMING FOR SEXUAL ABUSE



3. Sexual Orientation

The literature review indicated that lesbian and bisexual women are at high risk in relation to problematic substance use (Goettler & Pearce, 1991). Lesbian and bisexual women represent almost 25% of the total women interviewed. One of the major concerns identified was rejection from other clients and/or from counsellors if they disclosed their sexuality. Homophobia and heterosexism are common-place in many treatment and continuing care programs, according to these women.

One bisexual woman noted that other members of her continuing care group would ridicule her about her sexuality, particularly the men. Of the six other women who identified as lesbian or bisexual, none have disclosed their sexual orientation in a continuing care group, although some have told their A.A. sponsor, or have disclosed to a counsellor while in treatment. One woman spoke about raising the issue with her counsellor:

> ***It was OK. I guess. But I couldn't be open in my treatment group. I missed not having openness and understanding from other people.***

She felt that not being able to be open during her treatment and later in continuing care slowed her recovery.

The one man interviewed whose mother had committed suicide commented on how her sexual orientation affected her recovery. Noting that she had been active with A.A. for almost 25 years, he stated that not once did she disclose that she was a lesbian.

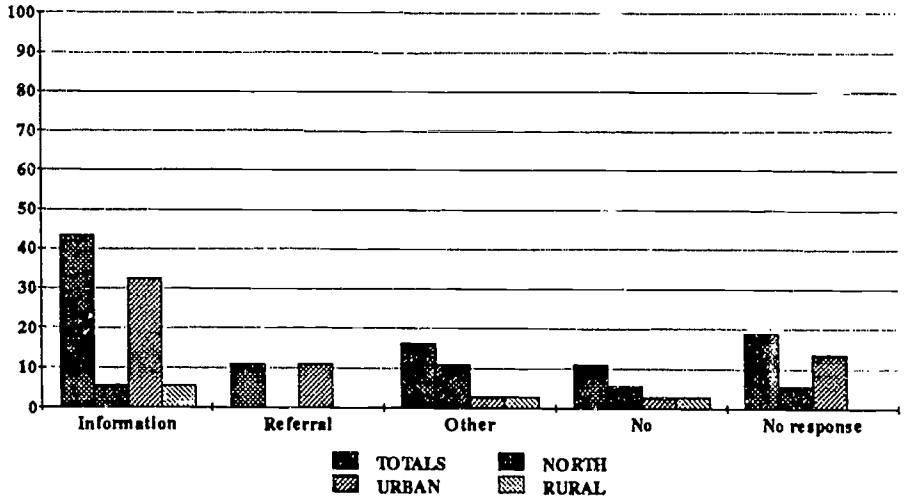
> ***In the last few years, she found that she couldn't work the program. There was no place for her sexuality which she had finally come to terms with.***

There is no doubt that the issue of sexuality is a contentious one. Many lesbians have reported that they were advised by counsellors not to disclose or discuss sexual orientation issues during the treatment process (Heyward, 1992).

Currently, little is available for women who identify as lesbian or bisexual in treatment or continuing care (see Figure 13). Only 43.2% of the agencies surveyed offer information on the range of human sexuality. In some cases, clients who identified as lesbian or bisexual were referred to other counsellors who deal with lesbian clientele. Another 19% of agencies did not respond at all to this question. Some agencies indicated they would help women come to terms with their sexuality. However, as was mentioned earlier, many women do not disclose for fear of rejection.

Do you provide programming sensitive to the needs of lesbian women?

FIGURE 13
AGENCY SERVICES - LESBIAN & BISEXUAL WOMEN

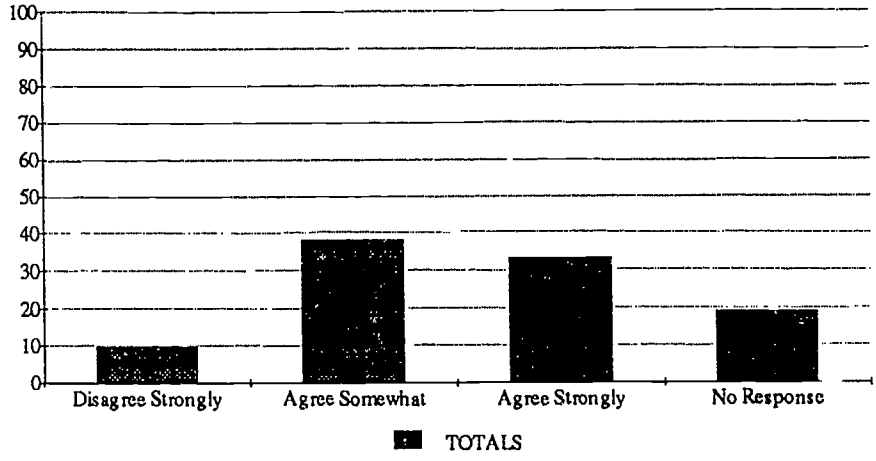


Many agency respondents stated that the organization had never experienced a problem with this issue because no lesbian or bisexual clientele had used their services. A few responded that they try to create a gay-positive atmosphere.

Despite the fact that lesbians and bisexual women face an alcoholism rate three to seven times higher than heterosexual women (Goettler & Pearce), agency support for programming in this area speaks to a void in understanding of the relationship between sexual orientation and substance use (see Figure 14). One third of agency respondents indicated that they somewhat supported programming in this area. Many did not respond at all, claiming that this was "not part of their agenda."

The study recommends that programs need to be responsive to lesbians. What do you think - and why?

FIGURE 14
AGENCY ATTITUDES TOWARDS
INCREASED PROGRAMMING FOR LESBIANS & BISEXUAL WOMEN



4. Accessibility

The issue of accessibility is a wide-ranging topic which reaches from issues of having buildings that are physically accessible by wheelchair, to having services and resource materials that reflect an appropriate literacy level. It also includes access to interpreters for women who do not have services in their first language, permission to continue the use of psychotropic drugs while in treatment and further technological support.

As earlier mentioned, 8% of women interviewed cited physical disabilities, noting that they at times had experienced difficulty with accessibility. One woman noted that she depended on others to get up the stairs to her continuing care group.

> ***There is one guy who helps me up the stairs, so if I want to go to a meeting, I call him to make sure he will be there to help.***

Three of the women interviewed cited difficulties during treatment and continuing care as a result of inappropriate literacy levels (often too high) and there being no translators when English was the second language. As one woman stated;

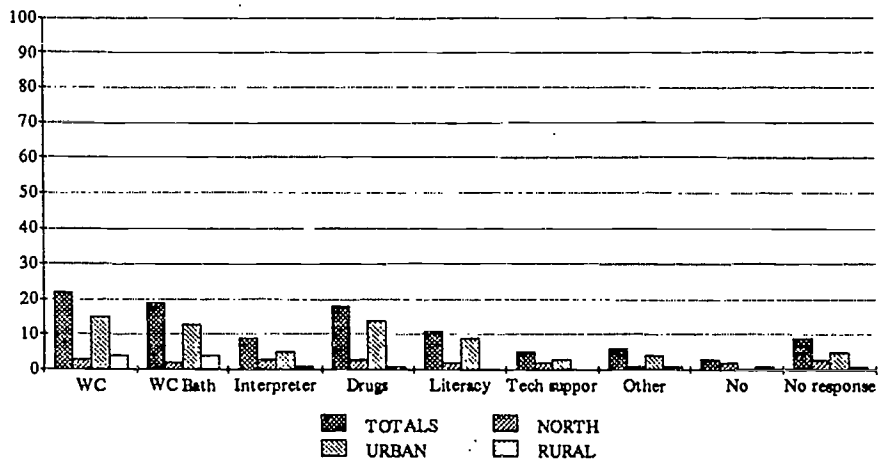
> ***The literacy level was too high - it should be brought down to street level.***

Many of the agency respondents cited limited funding and resources as a major barrier to improving accessibility. They also indicated a willingness to explore alternate arrangements for women with special needs such as coming into their home. This solution however only addresses one-to-one counselling.

Figure 15 outlines the percentage of services currently available for women who have specific access needs.

Do you provide programs sensitive to special needs women?

FIGURE 15
AGENCY SERVICES - ACCESSIBILITY

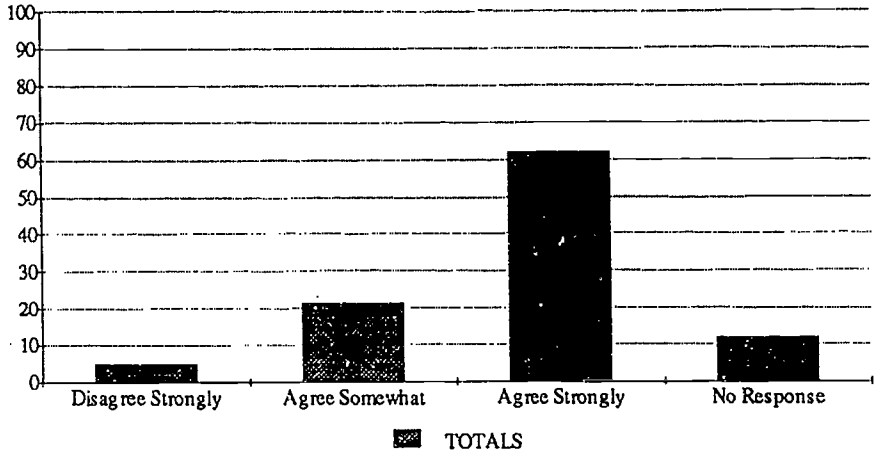


*WC refers to wheelchair accessibility & WC Bath refers to wheelchair-accessible washrooms.

Sixty-two percent agreed that programs need to be more responsive to women with special needs (see Figure 16).

The study recommends that there is a need for services to accommodate women with special needs. What do you think - and why?

FIGURE 16
AGENCY ATTITUDES TOWARDS INCREASED PROGRAMMING FOR ACCESSIBILITY

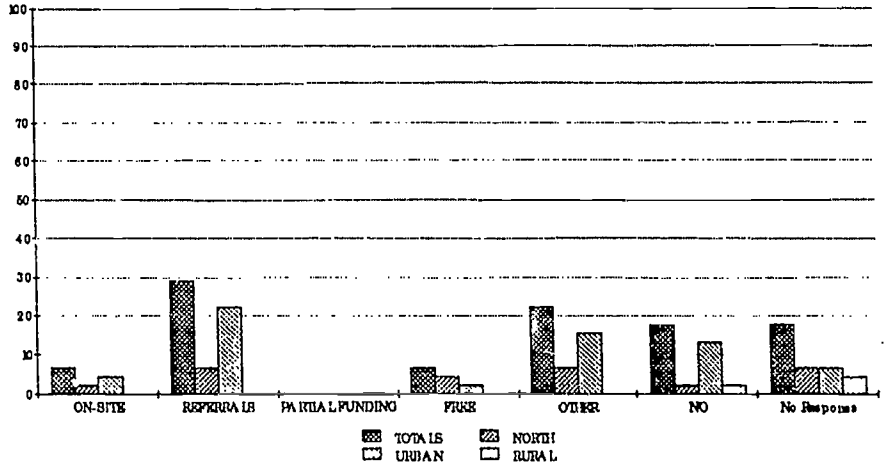


5. Childcare

A major barrier for women seeking treatment and continuing care is the availability of childcare (see Figure 17). Most of the women interviewed who had children indicated they had to arrange their own childcare prior to entering detox or treatment. In some cases women were afraid to leave children with abusive partners or to place their children in temporary foster care. Almost 45% of agencies either had no services available or simply did not respond to this question. Many of the referrals were to the Department of Social Services where women face the difficult option of placing their children in temporary care in order to participate in recovery services.

Do you provide childcare?

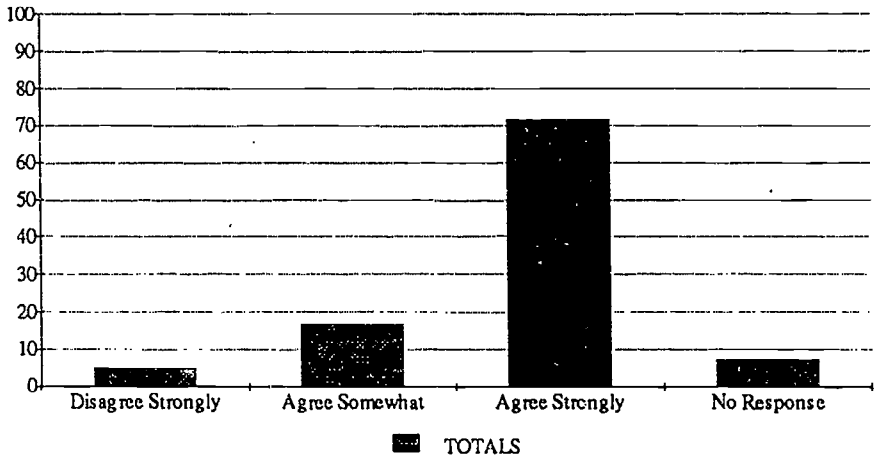
FIGURE 17
AGENCY SERVICES - CHILDCARE



Agencies recognize the lack of accessible childcare as a major barrier. Seventy percent strongly agreed that there needs to be improved accessibility (see Figure 18). As was cited regarding the issue of accessibility, however, limited funding and resources hamper many agencies.

The study recommends that childcare be accessible to women who need it. What do you think - and why?

FIGURE 18
AGENCY ATTITUDES TOWARDS INCREASED PROGRAMMING FOR CHILDCARE



6. Economic Barriers

The issue of adequate childcare is also an economic concern for both users and providers of services. Many agencies offer referrals, particularly to Social Services, to help women overcome a variety of economic barriers. For women not eligible for Social Assistance, financial help can be difficult to obtain. One woman commented that her partner refused to drive her to meetings. Had she not been able to make alternative arrangements by catching a ride with someone else, she would not have been able to access continuing care on a regular basis. Another woman spoke of the difficulties in relying on Social Assistance for support to attend continuing care:

> ***They [Social Services] pay for your transportation and childcare while you attend meetings, but they won't pay for a baby-sitter once the meeting is over. If you want to go for coffee with people in your group after the meeting, you have to pay for baby-sitting yourself.***

She added that going for coffee after meetings was one of the best ways to build a support network and to deal with issues that women didn't feel comfortable raising in the meetings.

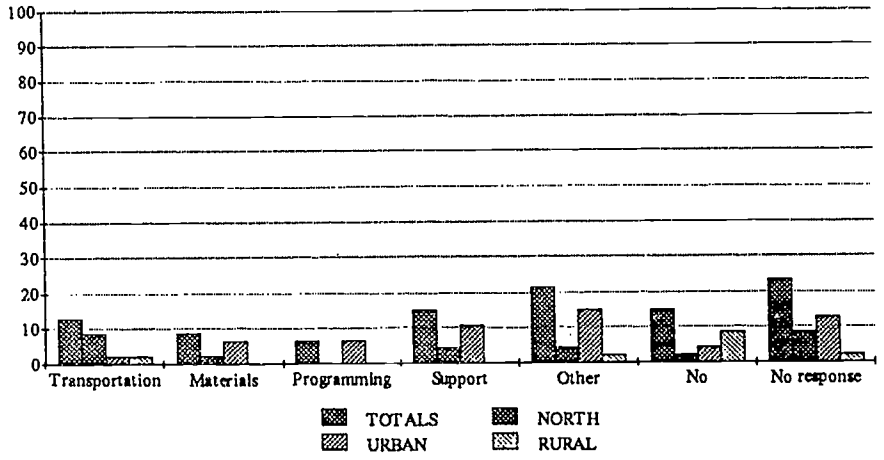
Another woman commented on the lack of support she received from her counsellor regarding financial issues and family responsibilities. She stated that the counsellor was very judgemental and unsupportive:

> ***Just about made me quit the program because of the way she talked to me. She make me feel so poor.***

Agency respondents indicated that if possible, they will make alternate arrangements when necessary. There is some provision for transportation and sliding scales for programs and materials. Figure 19 outlines the services currently available to address some of the economic barriers women face.

Do you provide programming sensitive to the economic realities of women's lives?

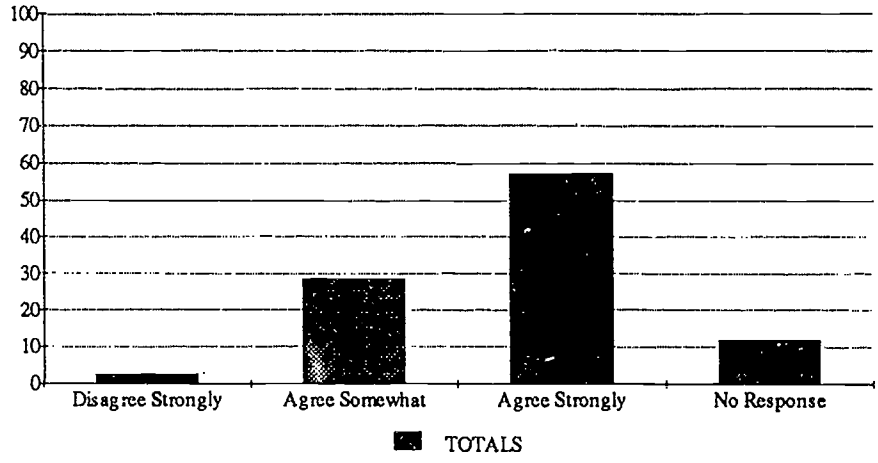
FIGURE 19
AGENCY SERVICES - ECONOMIC NEEDS



Despite limited resources, most respondents from agencies indicated that they strongly agree that economic needs should be further addressed (see Figure 20).

The study recommends that programs need to be responsive to the economic realities of women's lives. What do you think - and why?

FIGURE 20
AGENCY ATTITUDES TOWARDS
INCREASED PROGRAMMING FOR ECONOMIC NEEDS



7. Cultural Sensitivity

The issue of cultural sensitivity, particularly for Aboriginal women, is of concern to addiction service providers in Saskatchewan. According to statistics from SADAC, 56.7% of women seeking help for substance use are of Aboriginal ancestry (SADAC, 1992). In the 1991/92 fiscal year, Aboriginal people represented 46% of total SADAC clients, while constituting 7% of Saskatchewan's population (SADAC, 1993).

Of the women interviewed, 28.6% were Aboriginal or Metis. They identified a number of difficulties in treatment and continuing care including racism and isolation. One woman who has attended treatment centres in three urban communities comments:

> ***In treatment, there were no aboriginal women. All men were upper middle class and I just couldn't relate to them.***

Another woman commented that what had helped her most in recovery was native spirituality as she had no faith in Christianity. However, she noted that her spirituality is not always accepted in her continuing care groups .

Commenting on the racism experienced while in treatment and continuing care, one women observed that:

> ***The racism there is no worse than out on the streets.***

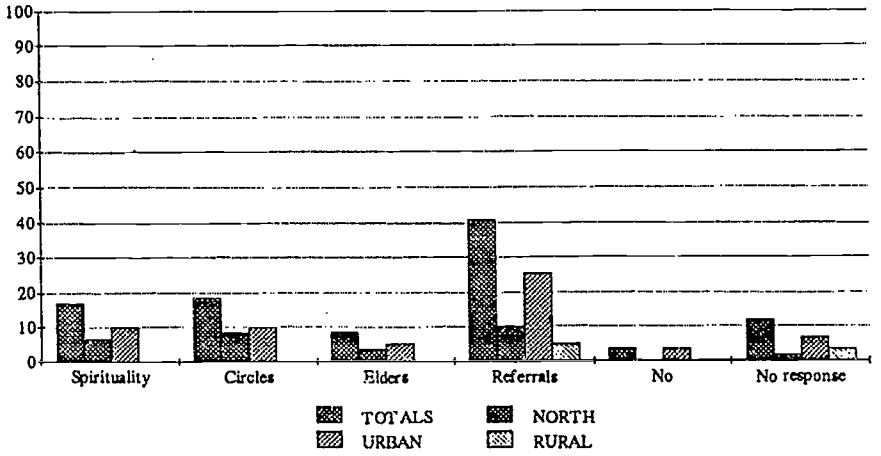
The level of racism greatly affects self-esteem and self-acceptance (Kasl, 1992). The effects of structural racism are apparent. Many of the Aboriginal women who seek

treatment are unemployed or underemployed, and have not completed Grade 12 (SADAC, 1993). As well a larger number of Aboriginal people have problems with more than one substance, usually a combination of alcohol and other drugs (SADAC, 1993).

Most agency respondents noted that they have some form of programming culturally specific for Aboriginal people although this consists of referrals for more than 25% of agencies (see Figure 21).

Do you provide programming sensitive to the needs of Aboriginal women?

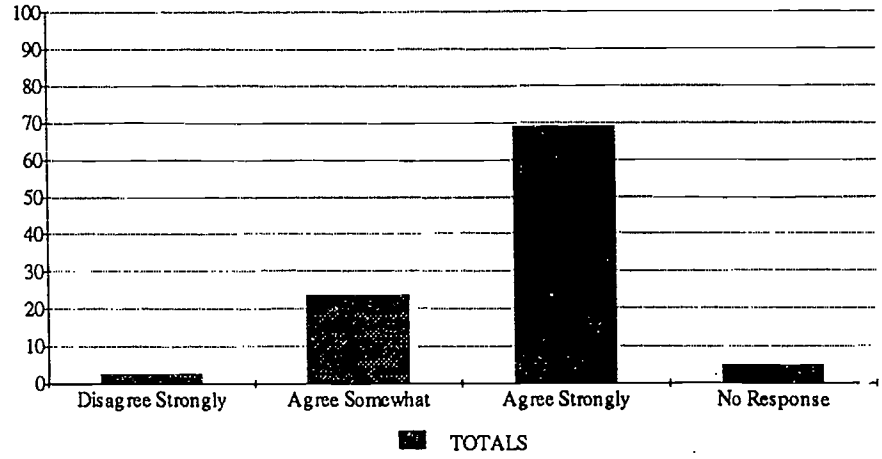
FIGURE 21
AGENCY SERVICES FOR ABORIGINAL WOMEN



Almost 70% of agencies agreed than an increase in specialized programming for Aboriginal women was necessary (see Figure 22).

The study recommends that programs should address the needs of Aboriginal women. What do you think - and why?

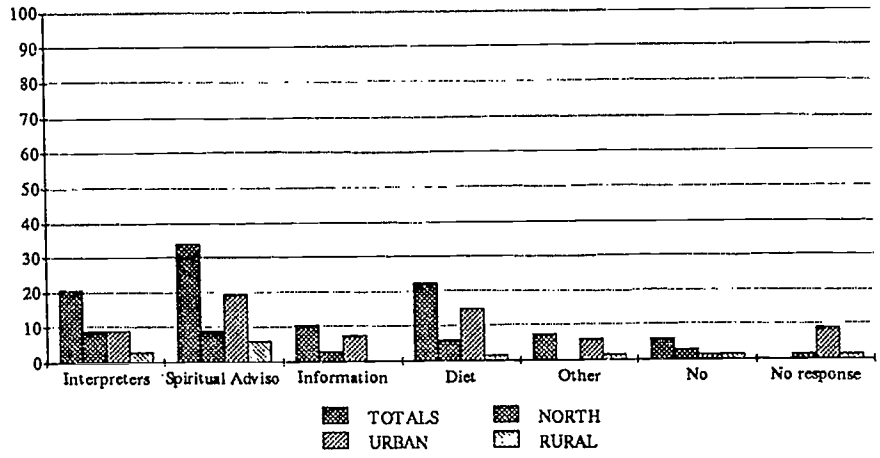
FIGURE 22
AGENCY ATTITUDES TOWARDS INCREASED PROGRAMMING FOR ABORIGINAL WOMEN



A major concern in the area of treatment and continuing care is to increase cultural and religious sensitivity for **all** women, reflecting the diverse backgrounds of women in Saskatchewan. Although no women of colour were interviewed, concerns still exist about the glaring lack of research into the issue of gender, race and recovery. Such omissions indicate the level of structural racism and sexism built into Canadian institutions. Services that reflect cultural and religious diversities are limited at best. Women are likely to have access to spiritual advisers of their choice. They are unlikely, however, to have access to an interpreter or special diet. Figure 23 indicates the services now available that accommodate cultural and religious diversity.

Do you provide programming sensitive to the needs of women who reflect cultural and spiritual diversity?

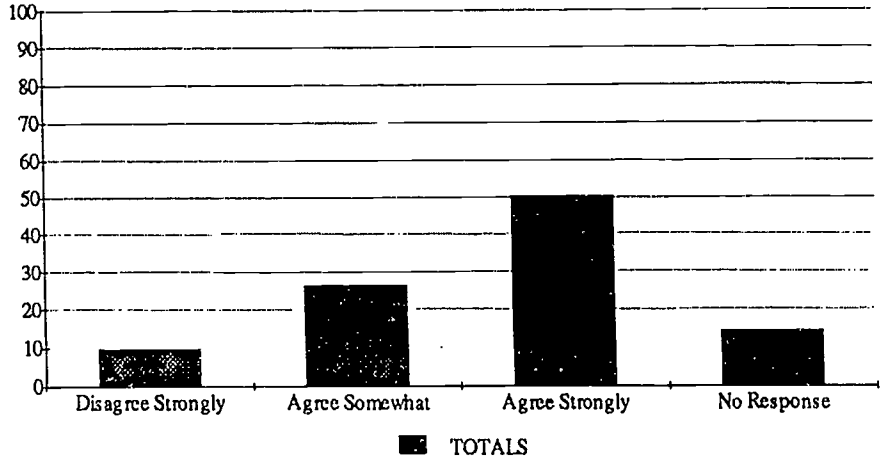
FIGURE 23
AGENCY SERVICES - CULTURAL/RELIGIOUS SENSITIVITY



Although the majority of agencies agreed that there is a need for increased sensitivity in this area (see Figure 24), there is no clear agreement on how this can be achieved. The entire issue is contentious and treated very cautiously. One respondent commented that often "these needs can be carried too far." This comment reflects a serious lack of understanding of the needs of women who are not white heterosexual Christians.

The study recommends that programs need to reflect the needs of women who represent cultural or religious diversities. What do you think - and why?

FIGURE 24
AGENCY ATTITUDES TOWARDS INCREASED PROGRAMMING FOR CULTURAL/RELIGIOUS SENSITIVITY



Regardless of attitudes within the agencies, women believed that issues such as racism and ethnocentrism need to be addressed. Many called for cross-cultural training and more

Aboriginal counsellors. As one woman mentioned earlier, being the only Aboriginal person in a group full of white people, the majority of whom are men, made it difficult to relate at times to the group.

8. Safe Places for Women

Of the women interviewed, 93% believed that having safe places for women to deal with substance use, recovery and other issues of importance is critical. Many commented that all women's groups and treatment centres would be very important. The following are some of the many comments women made regarding the issue of safe places for women.

> ***There are a lot of things I would not say or open up with in front of men because there is no understanding and smart remarks are made. Sexuality and issues surrounding sex cannot be discussed.***
>
> ***I have always said to be careful of what you air [in group]. Do that with your sponsor.***
>
> ***To me, a women's group or centre would have been ideal. If I would have had more women to talk to, I would have gotten help sooner. For me - to talk - it was very difficult.***
>
> ***SADAC wasn't a safe place for me. I went there to get information and remember feeling terror. What would have been safe was a group of women, or a female counsellor.***
>
> ***Women definitely need a place to go for help. It is far less acceptable for women to get drunk and obnoxious, therefore, confronting the problem seems to go on in a very inconspicuous manner.***
>
> ***It's important that we get into a safe environment. It should be longer than just for a couple of weeks. It takes time for a woman to settle down. She's so full of fear. She needs a lot of support at that time of her life.***
>
> ***If you can share your experience in a safe place you don't feel alone or judged. You can also be safe with yourself.***
>
> ***The meeting is a safe place to talk about alcohol and drugs but it's not safe to talk about lesbianism, sexual abuse or feelings as a child.***
>
> ***Meetings were a safe place for me, but you had to watch yourself. I was at a women's group in Winnipeg to talk about women's issues. It was excellent.***

I need a peer group.

Women do not need to be told that they are not good enough. They already feel this without anyone telling them this. What women need is the permission to tell the truth and to know that some of the things that happened to them were not their fault. Once they give back the responsibility, their recovery can take place.

I really see there are specific issues that men need to deal with in recovery and that women need to deal with in recovery.

A safe place for women is vital, without it you can slip through the cracks. People die from this disease.

Many women commented that men would pass judgement on them and that they wanted to recover in a non-shaming environment.

Another critical issue is "13-stepping", when someone is approached sexually by another member of their treatment or continuing care group. Although often greeted with giggles and smiles, this is very serious issue. More than 50% of women interviewed were approached sexually. Sixty-three percent noticed other women being approached sexually.

One woman commented that:

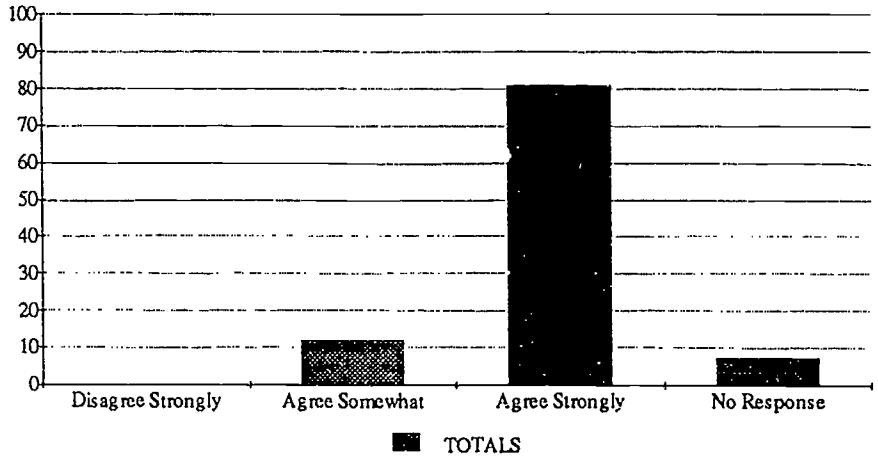
When I first started going to meetings, the old timers warned about guys like that.

Unfortunately not all women were warned of "13-stepping". One woman was sexually assaulted by one of the men in her continuing care group. Another woman noted that when women begin their recovery they are in an extremely vulnerable stage. She believes that women need support and need to be warned about those who might try to take advantage of them while in a vulnerable state.

Over 80% of responses from agencies strongly agreed that women need a safe place (see Figure 25).

The study recommends that women need a safe environment where they can come together and openly discuss their experiences. What do you think - and why?

FIGURE 25
AGENCY ATTITUDES TOWARDS INCREASED PROGRAMMING FOR SAFE PLACES FOR WOMEN



The question remains "What constitutes a safe place for women?"

ANALYSIS

When women were asked what they would like to see in the way of services for women, almost 90% responded that they would like to see some form of women-only services within the province. The services ranged from all-women continuing care support groups, to women-only treatment centres, to a women's health centre set up to deal with all aspects of physical and mental health which would be fully accessible to women and their children. The primary issue was and still is, that women need a place where they can feel safe to talk about delicate and painful issues such as abuse, racism, sexism, homophobia, sexuality, and poverty. What women wanted more than anything was a non-shaming environment where they could recover, and in the process, explore other issues that were important to them.

There are a number of centres established throughout Canada and the United States that are for women only. Examples include Maiya House on Vancouver Island (Walsh, 1991) and Amethyst Women's Addiction Centre in Ottawa. Both organizations offer treatment and continuing care based in feminist philosophy by approaching substance use as a complex issue interrelated with women's life experiences. Issues such as sexuality, self-esteem and abuse are all addressed.

The availability of life skills programs and assertiveness training courses was also recognized as important for many of the women interviewed. One woman pointed out that through assertiveness training she felt confident to take on leadership roles within her support group. Another woman believed that life skills programs have given her the coping mechanisms she was searching for and she no longer uses substances as a crutch. The element common to both stories is empowerment.

All of the women interviewed were at one point, or still are, active with Alcoholics Anonymous (A.A.). Participating in a group that included both men and women caused difficulties for some women. Some women addressed those concerns by adapting the program to their own needs and by developing a strong support group with other female A.A. members within their home group. Others have joined other groups in addition to A.A. Yet others simply stopped participating. One woman commented on the isolation she experienced when attending meetings:

> ***I felt like I didn't fit in. Any time I went to a meeting, I left feeling more depressed and despair than when I went. There was nobody there who I could relate to or who cared to relate to me.***

Of those who were still active, many believed that being able to relate to other people who had problems with substance use was critically important. All agreed that there were some issues that were not safe to discuss, such as sexuality, abuse, and sexual orientation. They cited the strong male influence with the organization as problematic. One woman commented that she believed that the

Sexism in A.A. is a reflection of the sexism within society in general. Women are treated like shit, like second class citizens.

She continued on advising women to:

Stand up for yourself, be assertive and don't take any crap from a man. Don't let anyone stop you from getting what you want or what you need to be doing.

It is important to note that many women credited A.A., particularly the 12 step program, with having a pivotal role in their sobriety. Yet as Kasl points out, there are many different ways of overcoming problems with substance use (Kasl, 1992). A number of alternatives to A.A. have been developed including Women For Sobriety (W.F.S.) which has developed a step program based on empowerment (Kaskutas, 1992). Appendix 4 lists three different types of step programs including A.A., W.F.S., and the Feminist Twelve Steps, as well as a short history on each. The availability of a number of continuing care programs is important not only to the women interviewed, but to service providers. As Kaskutas notes;

> "...there is evidence that a single track of treatment for alcoholism, ignoring patient differentiations, is not appropriate. The practice of not matching clients to specific programs contributes to poor outcomes, while the existence of treatment choices contributes both to the likelihood of compliance and to success."
>
> (Kaskutas, 1992, p. 633)

Regardless of what kind of continuing care women choose to use, two important themes emerge.

1) Women need to feel safe to discuss all the issues that relate to their recovery, and

2) This must occur in an accessible, supportive environment.

Individualized counselling is also an important part of successful recovery. Nearly 60% of women interviewed wanted to see more individual counselling as another option for women seeking services. Ideally, this counselling would address the issues of sexuality, abuse and accessibility, by having counsellors trained in these areas and by having a staff that reflected the diverse racial and cultural make-up of society.

Of those who responded to the agency surveys, most indicated support for the expansion of services for women and for services that are more inclusive than what currently exist. The greatest area of agreement was regarding reducing barriers related to childcare and economic realities of women seeking services, with more than 80% strongly supporting increased programming and assistance. In other areas, particularly increased programming based on sexual orientation and cultural sensitivity, responses were not as supportive.

This raises a concern regarding accessibility for women who are high risk, including Aboriginal women, lesbian and bisexual women, and women living with disabilities. A recent paper produced by SADAC's Evaluation and Research Unit (1993) identified the need to focus on these populations, as well as for women of colour and the elderly.

The success of service providers to reach these target populations will depend on;

1) Education for service providers regarding the specific needs and concerns of women within these populations, and

2) Funding to develop programming in these areas.

Limited resources was often cited as a reason why agency respondents had little or no programming in the areas of accessibility, cultural sensitivity and sexual orientation. Both policy makers in government and service providers must prioritize funding in order to reach women within these populations.

RECOMMENDATIONS

The report recommends the following:

*** THAT SERVICES FOR PROBLEMATIC SUBSTANCE USERS MUST MEET THE NEEDS OF WOMEN SEEKING RECOVERY.**
These services must be:

- *** geographically accessible,**
- *** financially accessible,**
- *** accessible to women with disabilities, Aboriginal women, lesbian and bisexual women, older women, women of colour, survivors of abuse.**

*** THAT PROFESSIONALS, SERVICE PROVIDERS AND POLICY MAKERS RECEIVE TRAINING AND EDUCATION ON ABUSE ISSUES, AND GENDER EQUITY, CROSS CULTURAL TRAINING AND UPDATES REGARDING RESEARCH ON WOMEN AND PROBLEMATIC SUBSTANCE USE.**

*** THAT GENDER AND CULTURAL SENSITIVITY AND SENSITIVITY TO ABUSE ISSUES BE CENTRAL IN SUBSTANCE USE RECOVERY AND CONTINUING CARE PROGRAMS.**

*** THAT WOMEN-ONLY AND ABORIGINAL-SPECIFIC RECOVERY SERVICES BE DEVELOPED AND MADE AVAILABLE THROUGHOUT SASKATCHEWAN INCLUDING;**

- *** treatment centres,**
- *** holistic health clinics,**
- *** individualized counselling,**
- *** continuing care programs.**

*** THAT CHILDCARE BE MADE AVAILABLE FOR WOMEN THROUGHTOUT RECOVERY INCLUDING;**

- *** detoxification centres,**
- *** in-patient and out-patient services,**
- *** continuing care programs.**

*** THAT SERVICES MUST REFLECT THE VARIED LITERACY LEVELS OF CLIENTELE. THIS WOULD INCLUDE ACCESS TO ONE'S FIRST LANGUAGE, OR WHEN THAT OPTION IS NOT POSSIBLE, ACCESS TO AN INTERPRETER.**

* THAT A MONTHLY OR BI-MONTHLY NEWLETTER INITIATIVE BE EXPLORED, WHICH WOULD INCLUDE CONTRIBUTIONS FROM SASKATCHEWAN WOMEN.

* THAT A COALITION OF SERVICE PROVIDERS AND WOMEN WHO HAVE SOUGHT SERVICES BE FORMED. THIS WOULD INCLUDE PEOPLE FROM THE FOLLOWING AREAS:

- * addiction services,
- * mental health,
- * justice,
- * women's advocacy groups.

* THAT CONTINUED PUBLIC INFORMATION INCLUDE THE SPECIAL NEEDS OF WOMEN IN SUBSTANCE USE RECOVERY PROGRAMS.

* THAT RESEARCH FOR, BY AND ABOUT WOMEN BE CONTINUED AND REFLECT THE PROVINCE'S DIVERSE POPULATION INCLUDING:

- * Aboriginal women, and women of colour,
- * women with disabilities,
- * lesbian and bisexual women,
- * older women.

* THAT THE PROMOTION AND PROTECTION OF THE OVERALL WELL-BEING OF WOMEN BE MAINTAINED AS AN ULTIMATE GOAL.

* THAT WOMEN BE INVITED AND ENCOURAGED TO ACTIVELY PARTICIPATE IN THE DEVELOPMENT AND EVALUATION OF PROGRAMS AND RELATED POLICIES THAT PERTAIN TO SUBSTANCE USE RECOVERY FOR WOMEN.

CONCLUSION

Above all, the key to successful recovery for women is to have a variety of options to choose from when seeking treatment and continuing care. While some options do exist, information is difficult to find on how to access these options. The dissemination of this information is critical. The easier it is for women to find the resources and services they are seeking, the more likely it is that they will pursue them.

Accessibility for women is as important as options. Women face economic, cultural and physical barriers that must be acknowledged and addressed in order to improve accessibility. Determining the best way to address these barriers must be done by exploring their origins (i.e. racism, sexism, ableism, heterosexism and ethnocentrism) and consulting with those affected to develop a joint strategy for eliminating these obstacles.

The final words are left to a woman who emphatically encapsulated the issue of options and accessibility as it relates to recovery.

> ***I deserve this! Every woman deserves this!***

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Tradewell, R.L. (March 1993). "Is gender-specific treatment better than c educational treatment?". The Addiction Newsletter. p. 2.

Walsh, H. (November 1991). "Feminist treatment is key". Kinesis. p.11.

Women and Substance Use Advisory Committee. (January, 1992). Final Report.

APPENDIX 1

AGENCY LISTINGS

Alcohol & Drug Services, Saskatchewan Health(formerly SADAC)

Central Regional Services
122 3rd Avenue North
Saskatoon, Saskatchewan
S7H 2H6

North Battleford Regional Office
1146 102nd Street
North Battleford, Saskatchewan
S9A 1E9

Saskatoon Regional Office
122 3rd Avenue North
Saskatoon, Saskatchewan
S7H 2H6

Calder Out-Patient Clinic
122 3rd. Avenue North
Saskatoon, Saskatchewan
S0M 2J0

Southern Regional Services
2140 Hamilton Street
Regina, Saskatchewan
S4P 3V7

Regina Regional Office
2140 Hamilton Street
Regina, Saskatchewan
S4P 3V7

Weyburn Regional Office
110 Souris Avenue Northeast
Weyburn, Saskatchewan
S4H 2Z9

Myers Recovery Centre
2140 Hamilton Street
Regina, Saskatchewan S4P 3V7

Melfort Regional Office
P.O. Box 6500
Melfort, Saskatchewan
S0E 1A0

Prince Albert Regional Office
P.O. Box 3003
Prince Albert, Saskatchewan
S6V 6G1

Northern Regional Services
P.O. Box 5000
La Ronge, Saskatchewan
S0J 1L0

La Ronge Regional Office
Box 5000
La Ronge, Saskatchewan
S0J 1L0

Moose Jaw Regional Office
110 Ominica Street West - Suite 28
Moose Jaw. Saskatchewan
S6H 6V2

Swift Current Regional Office
350 Cheadle Street West
Swift Current, Saskatchewan
S9H 4G3

Yorkton Regional Office
Broadcast Place, 120 Smith Street
Yorkton, Saskatchewan
S3N 3V3

Calder Rehabilitation Centre
2003 Arlington Avenue
Saskatoon, Saskatchewan
S7K 2H6

Calder Centre
2003 Arlington Avenue
Saskatoon, Saskatchewan
S7K 2H6

Alcohol & Drug Services, Saskatchewan Health - Funded Agencies)

Addictions Counselling Unit
Melfort Union Hospital
P.O. Box 1480
Melfort, Saskatchewan
S0E 1A0

Beaval Out-patient Centre
P.O. Box 19
Beauval, Saskatchewan
SOM 0G0

Breton Addictions Centre
P.O. Box 1595
North Battleford, Saskatchewan
S9A 3W1

CADAC Out-Patient Centre
P.O. Box 760
Creighton, Saskatchewan
S0P 0A0

Clearwater Alcohol Rehabilitation and
Education Centre, Inc.
P.O. Box 98
La Ronge, Saskatchewan
S0M 1G0

Palliser Alcohol & Drug Abuse Committee
P.O. Box 1453
Swift Current, Saskatchewan
S9H 3X5

Danny Fisher Centre
P.O. Box 1688
Kindersley, Saskatchewan
S0L 1S0

George Bailey Centre
P.O. Box 2764
Humboldt, Saskatchewan
S0K 2A0

Hudson Bay & District
Assessment & Referral Service
P.O. Box 898
Hudson Bay, Saskatchewan
S0E 0Y0

Kiyenaw Out-Patient Centre
P.O. Box 460
Buffalo Narrows, Saskatchewan
S0M 0J0

Mitho Menoo Out-Patient Centre
La Ronge Alcohol & Drug Ed.
P.O. Box 1185
La Ronge, Saskatchewan
S0J 1L0

Moose Mountain Alcohol & Drug
Rehabilitation Society
P.O. Box 699
Kipling, Saskatchewan
S0G 2S0

Parkland Alcohol & Drug Abuse
Society, Inc.
41 Broadway Street West, Suite 35
Yorkton, Saskatchewan S3N OL6

Prince Albert Council on Alcohol
& Drug Abuse (PACADA)
101 15th Street East
Prince Albert, Saskatchewan
S6V 1G1

Sandy Bay Out-Patient Clinic
P.O. Box 40
Sandy Bay, Saskatchewan
S0P 0G0

Angus Campbell Centre
P.O. Box 118
Moose Jaw, Saskatchewan
S6H 4N7

Larson Intervention House Inc.
130 Avenue O South
Saskatoon, Saskatchewan
S7M 2R5

Hopeview Recovery Home
1891 96th Street
North Battleford, Saskatchewan
S9A 0J1

Pine Lodge Treatment Centre
P.O. Box 457
Indian Head, Saskatchewan
S0G 2K0

St. Joseph's Treatment Centre
St. Joseph's Hospital
1401 1st Street
Estevan, Saskatchewan
S4A 0H3

Pine Island Out-Patient Centre
P.O. Box 218
Cumberland House, Saskatchewan
S0E 0S0

Robert Simard Centre
Northland Alcohol & Drug Society
P.O. Box 2617
Meadow Lake, Saskatchewan
S0M 1V0

Saul Cohen Centre
P.O. Box 164
Melville, Saskatchewan
S0A 2P0

Addiction Services
Kipling Memorial Union Hospital
P.O. Box 420
Kipling, Saskatchewan
S0G 2S0

Detox Centre
2839 Victoria Avenue
Regina, Saskatchewan
S4T 1K6

Northwest Alcohol & Drug Abuse Centre
P.O. Box 129
Ile-a-La-Crosse, Saskatchewan
S0M 1C0

Recovery Manor
2825 Victoria Avenue
Regina, Saskatchewan
S4T 1K6

St. Louis Alcoholism Rehabilitation Centre
Impaired Driver Treatment Program
P.O. Box 220
St. Louis, Saskatchewan
S0J 2C0

Whitespruce Youth Treatment Centre
P.O. Box 1411
Yorkton, Saskatchewan
S3N 3G3

National Native Alcohol & Drug Abuse Program(NNADAP)

Carry the Kettle Alcohol
& Drug Abuse Resource Centre
P.O. Box 57
Sintatluta, Saskatchewan
S0G 4N0

Cote Band
Saulteaux Centre
P.O. Box 938
Kamsack, Saskatchewan
S0A 1S0

Cowessess Drop-In Centre
P.O. Box 159
Broadview, Saskatchewan
S0G 0K0

Fishing Lake Human Development Project
P.O. Box 508
Wadena, Saskatchewan
S0A 4J0

Gordon-Daystar Drop-In Centre
P.O. Box 484
Punnichy, Saskatchewan
S0A 3C0

Kahkewistahaw Drop-In Centre
P.O. Box 609
Broadview, Saskatchewan
S0G 0K0

Keeseekoose Drug & Alcohol
Awareness Program
P.O. Box 1120
Kamsack, Saskatchewan
S0A 1S0

Key Band
Pee Machee O Win Program
Box 70
Norquay, Saskatchewan
S0A 2V0

Little Black Bear Prevention Program
P.O. Box 40
Goodeve, Saskatchewan
S0A 1C0

Muskowekwan Drop-In Centre
P.O. Box 298
Lestock, Saskatchewan
S0A 2G0

Muscowpetung Drop-In Centre
P.O. Box 1310
Fort Qu'Appelle, Saskatchewan
S0G 1S0

Nikaneet Community Prevention Project
P.O. Box 548
Maple Creek, Saskatchewan
S0N 1N0

Ochapowace Counselling & Referral Centre
P.O. Box 718
Broadview, Saskatchewan
S0G 0K0

Okanese Drug & Alcohol Awareness Program
P.O. Box 759
Balcarres, Saskatchewan
S0G 0C0

Pasqua Drop-In Centre
P.O. Box 968
Fort Qu'Appelle, Saskatchewan
S0G 1S0

Peepeekisis Alcohol & Drug Services Program
P.O. Box 518
Balcarres, Saskatchewan
S0G 0C0

Piapot Drop-In Centre
General Delivery
Zehner, Saskatchewan
S0G 5K0

Poorman Drop-In Centre
General Delivery
Quinton, Saskatchewan
S0A 3G0

Sakimay Drop-In Centre
Box 339
Grenfell, Saskatchewan
S0G 2B0

Standing Buffalo Band
Dakota Drop-In Centre
P.O. Box 818
Fort Qu'Appelle, Saskatchewan
S0G 1S0

Starblanket Alcohol & Drug Abuse Program
P.O. Box 456
Balcarres, Saskatchewan
S0G 1S0

White Bear Drop-In Centre
P.O. Box 700
Carlyle, Saskatchewan
S0C 0R0

Wood Mountain Prevention
P.O. Box 112
Wood Mountain, Saskatchewan
S0H 4L0

Detox Recovery Centre
Fort Qu'Appelle Indian Hospital
3rd Floor
P.O. Box 220
Fort Qu'Appelle, Saskatchewan
S0G 1S0

Kamsack Union Hospital Alcohol & Drug Treatment Program
P.O. Box 429
Kamsack, Saskatchewan
S0A 1S0

New Dawn Valley Centre Inc.
P.O. Box 188
Fort Qu'Appelle, Saskatchewan
S0G 1S0

Big C Alcohol & Drug Abuse Program
P.O. Box 389
La Loche, Saskatchewan
S0M 1G0

Buffalo River Alcohol & Drug Abuse Program
Dillon, Saskatchewan
S0M 0S0

Canoe Lake Alcohol & Drug Abuse Program
Canoe Narrows, Saskatchewan
S0M 0S0

English River Alcohol & Drug Abuse Program
General Delivery
Patuanak, Saskatchewan
S0M 1V0

Island Lake Alcohol & Drug Abuse Program
P.O. Box 460
Loon Lake, Saskatchewan
S0M 1L0

Joseph Bighead Alcohol & Drug Abuse Program
P.O. Box 309
Pierceland, Saskatchewan
S0M 2J0

Little Pine Alcohol & Drug Abuse Program
P.O. Box 70
Paynton, Saskatchewan
S0M 2J0

Makwa Sahgaiehcan Alcohol & Drug Abuse Program
P.O. Box 178
Loon Lake, Saskatchewan
S0M 1L0

Moosomin Alcohol & Drug Abuse Program
P.O. Box 98
Cochin, Saskatchewan
S0M 0L0

Mosquito Alcohol & Drug Abuse Program
P.O. Box 177
Cando, Saskatchewan
S0K 0V0

Onion Lake Drop-In Centre
General Delivery
Onion Lake, Saskatchewan
S0M 2E0

Poundmaker Alcohol Project
P.O. Box 220
Paynton, Saskatchewan
S0M 2J0

Red Pheasant Alcohol & Drug Abuse Program
P.O. Box 70
Cando, Saskatchewan
S0K 0V0

Saulteaux Alcohol & Drug Abuse Program
P.O. Box 147
Cochin, Saskatchewan
S0M 0L0

Sweetgrass Alcohol & Drug

Thunderchild Alcohol & Drug Abuse

Abuse Program
P.O. Box 147
Gallivan, Saskatchewan
S0M 0X0

Turnor Lake Alcohol & Drug
Abuse Program
General Delivery
Turnor Lake, Saskatchewan
S0M 3E0

Ekweskeet Rehab Centre
Onion Lake, Saskatchewan
S0M 2E0

Beardy's & Okemasis Band
Alcohol & Drug Abuse Program
P.O. Box 340
Duck Lake, Saskatchewan
S0K 1J0

Black Lake Band
(Athabasca Project)
Northern Lights Drop-In Centre
General Delivery
Black Lake, Saskatchewan
S0J 0H0

Fond du Lac Band
(Athabasca Project)
West Side Fond du Lac
Drop-In Centre
Fond du Lac, Saskatchewan
S0J 0W0

James Smith Band Alcohol &
Drug Abuse Project
P.O. Box 480
La Ronge, Saskatchewan
S0J 1L0

Montreal Lake Band
Program
General Delivery
Turtleford, Saskatchewan
S0M 3E0

Waterhen Lake Alcohol & Drug
Abuse Program
Watherhen Lake, Saskatchewan
S0M 3B0

Ahtahkakoop Band Alcohol & Drug
Abuse Program
P.O. Box 220
Shell Lake, Saskatchewan
S0J 2G0

Big River Band Alcohol & Drug
Abuse Program
P.O. Box 519
Debden, Saskatchewan
S0J 0S0

Cumberland House Alcohol & Drug
Abuse Program
P.O. Box 220
Cumberland House, Saskatchewan
S0E 0S0

Hatchet Lake Band
(Athabasca Project)
Welcome Bay Drop-In Centre
General Delivery
Wollaston Lake, Saskatchewan
S0J 3C0

Lac La Ronge Alcohol & Drug
Abuse Project
P.O. Box 480
La Ronge, Saskatchewan
S0J 1L0

Pelican Lake Band Alcohol & Drug

NNADAP Program
William Charles Health Centre
General Delivery
Montreal Lake, Saskatchewan
S0J 1Y0

Peter Ballantyne Band
Weichi Drop-In Centre
General Delivery
Pelican Narrows, Saskatchewan
S0P 0E0

Saskatoon District Tribal Council
Drug & Alcohol Abuse Project
226 Cardinal Crescent
Saskatoon, Saskatchewan
S7L 6H8

Sturgeon Lake Alcohol & Drug
Abuse Program
Box 5, Site 12, R.R. #1
Shellbrook, Saskatchewan
S0J 2E0

Witchekan Lake Band Alcohol
& Drug Abuse Project
P.O. Box 879
Spiritwood, Saskatchewan
S0J 2M0

Cree Nation Treatment Haven
P.O. Box 340P.O.
Canwood, Saskatchewan
S0J 2R0

Abuse Program
P.O. Box 399
Leoville, Saskatchewan
S0J 1N0

Red Earth Band
Minnegowin Control Project
P.O. Box 109
Red Earth, Saskatchewan
S0E 1K0

Shoal Lake Band Alcohol & Drug
Abuse Program
P.O. Box 51
Shoal Lake, Saskatchewan
S0E 1G0

Wahpeton Alcohol & Drug
Abuse Program
P.O. Box 128
Prince Albert, Saskatchewan
S6V 5R4

Athabasca Alcohol & Drug
Abuse Program
Stony Rapids, Saskatchewan
S0J 2R0

Sakwatamo Lodge
Box 3917
Melfort, Saskatchewan
S0E 1A0

OTHER AGENCIES

Sober Dykes
P.O Box 8581
Saskatoon, Saskatchewan
S7H 6K7

Addictions Education Program
P.O. Box 3003
Pine Grove Correctional Centre
Prince Albert, Saskatchewan
S6V 6G1

Prince Albert Tribal Council
Health and Social Development Program
P.O. Box 2350
Prince Albert, Saskatchewan
S6V 6Z1

Health & Social Development Project
Sturgeon Lake Band Office
Comp 5, R.R. #1, Site 12
Shellbrook, Saskatchewan
S0J 2E0

Family Service Centre
Kikinahk--Indian & Metis
Friendship Centre
La Ronge, Saskatchewan
S0J 1L0

Prince Albert Mobile Crisis Unit
1100 1st Avenue East
Prince Albert, Saskatchewan
S7V 2A7

Women For Sobriety
c/o Central Lutheran Church
2625 12th Avenue
Regina, Saskatchewan
S4T 1J1

Salvation Army
Women's Substance Problems
802 Queen Street
Saskatoon, Saskatchewan
S7K 0N1

Rainbow Youth Centre
1806 Albert Street
Regina, Saskatchewan
S4P 2G8

B.N. Lutz & Associates
Counselling Services
420 Souris Avenue
Weyburn Saskatchewan S4H 0C8

Healing Circle Project
1100 1st Avenue East
Prince Albert, Saskatchewan
S7V 2A7

The Street Project
1910 McIntyre Street
Regina, Saskatchewan
S4P 2R3

Disease Control Program
Room 101, Idylwyld Drive North
Saskatoon, Saskatchewan
S7K 0Z2

Prince Albert Co-operative Health Centre
110 8th Street East
Prince Albert, Saskatchewan
S6V 0V7

Salvation Army
Women's Substance Problems
2301 15th Avenue
Regina, Saskatchewan
S4P 1A3

Elks Purple Cross Fund
Elks & Royal Purple Drug Awareness
Program
2629 29th Avenue, Suite 100
Regina, Saskatchewan
S4S 2N9

RCMP Drug Awareness Program
P.O. Box 2500
Regina, Saskatchewan
S4P 3K7

APPENDIX 2

AGENCY SURVEY & FREQUENCY TABLES

PART ONE: NON-CONFIDENTIAL

1. WHAT IS YOUR AGENCY'S NAME?

2. WHAT IS THE ADDRESS OF YOUR AGENCY?

3. WHAT IS THE TELEPHONE NUMBER OF YOUR AGENCY?

4. WHAT ARE YOUR HOURS OF OPERATION?

5. IS THERE A FEE FOR YOUR SERVICES?

6. IS THERE A WAITING LIST FOR YOUR SERVICES?

7. WHAT ARE THE LANGUAGES SPOKEN AT YOUR AGENCY?
   (example: English, French, some Cree)

8. WHAT IS YOUR CLIENTS' AVERAGE LENGTH OF STAY?

9. HOW MANY BEDS DOES YOUR AGENCY HAVE?
   (if applicable)

10. HOW DO PEOPLE ACCESS YOUR SERVICES?
    (example: self-referral, etc.)

11. WHOM MAINLY DO YOU SERVE?
    (example: men, youths, Aboriginal people, etc.)

11a. WHAT PERCENTAGE OF YOUR CLIENTELE IS WOMEN?
    (an approximate estimate is sufficient)

( )	( )	( )	( )	( )	( )
0-10%	10-20%	20-40%	40-60%	60-80%	80-100%

TABLE 11a.
PERCENTAGE OF WOMEN CLIENTELE

	0 - 10%	10-20%	20-40%	40-60%	60-80%	80-100%	No response	TOTALS
TOTALS	1	1	16	12	5	5	2	42
NORTH	0	0	5	4	1	1	0	11
URBAN	0	1	6	8	4	4	1	24
RURAL	1	0	5	0	0	0	1	7

12. WHAT TYPE OF SERVICE DO YOU PROVIDE?

( ) detox
( ) half-way house
( ) in-patient
( ) out-patient
( ) prevention/education
( ) community
( ) school based
( ) self-help
( ) after-care
( ) other

TABLE 12
TYPES OF SERVICES

DETOX	1/2 WAY HOUSE	IN PATIENT	OUT PATIENT	PREVENTION	COMMUNITY	SCHOOL-BASED	SELF-HE	AFTER CARE	OTHER	TOTALS
3	0	6	27	31	25	11	16	29	15	163

13. PLEASE DESCRIBE THE SERVICES YOU PROVIDE.

14. DOES YOUR AGENCY PROVIDE ANY OF THE FOLLOWING SERVICES:

A. DO YOU PROVIDE ACCESS TO CHILDCARE?

( ) on-site childcare
( ) referrals to other childcare agencies
( ) some funding for childcare
( ) free childcare
( ) other -- please explain

TABLE 14A
ACCESS TO CHILDCARE

	ON-SITE	REFERRA	PARTIAL FUNDI	FREE	OTHE	NO	No Response	TOTALS
TOTALS	3	13	0	3	10	8	8	45
NORTH	1	3	0	2	3	1	3	13
URBAN	2	10	0	1	7	6	3	29
RURAL	0	0	0	0	0	1	2	3

B. DO YOU PROVIDE PROGRAMMING SENSITIVE TO THE NEEDS OF ABORIGINAL WOMEN?

( ) native spirituality
( ) healing circles
( ) elder programs
( ) culturally relevant referrals
( ) other -- please explain

TABLE 14B
SERVICES FOR ABORIGINAL WOMEN

	Spirituality	Circles	Elders	Referrals	No	No response	TOTALS
TOTALS	10	11	5	24	2	7	59
NORTH	4	5	2	6	0	1	18
URBAN	6	6	3	15	2	4	36
RURAL	0	0	0	3	0	2	5

C. DO YOU PROVIDE PROGRAMMING TO ADDRESS THE ISSUES OF FAMILY VIOLENCE?

( ) information on the cycle of violence
( ) refer to family violence agencies
( ) provide women-only counselling
( ) other -- please specify

TABLE 14C
SERVICES FOR DOMESTIC VIOLENCE

	Information	Referral	Women-only counsel	Other	No response	TOTALS
TOTALS	30	35	20	8	3	96
NORTH	9	8	3	1	1	24
URBAN	18	23	14	6	0	61
RURAL	3	4	1	1	2	11

D. IF A WOMAN IS IDENTIFIED AS BEING A VICTIM OF FAMILY VIOLENCE DURING TREATMENT, WHAT IS YOUR AGENCY'S RESPONSE?

E. DO YOU PROVIDE PROGRAMMING SENSITIVE TO THE ECONOMIC REALITIES OF WOMEN'S LIVES?

( ) transportation
( ) sliding scale of fees for materials
( ) sliding scale of fees for programming
( ) support for parental responsibilities
( ) other -- please explain

TABLE 14E
SERVICES FOR ECONOMIC ASSISTANCE

	Transportation	Materials	Programming	Support	Other	No	No response	TOTALS
TOTALS	6	4	3	7	10	7	11	48
NORTH	4	1	0	2	2	1	4	14
URBAN	1	3	3	5	7	2	6	27
RURAL	1	0	0	0	1	4	1	7

F. DO YOU PROVIDE PROGRAMMING ADDRESSING THE ISSUE OF THE SEXUAL ABUSE A WOMAN MAY HAVE EXPERIENCED AS AN ADULT OR CHILD?

( ) information about sexual abuse issues
( ) referrals to other agencies
( ) women only counselling groups
( ) include abuse agencies in your programs
( ) other -- please specify

TABLE 14F
SERVICES FOR SURVIVORS OF SEXUAL ABUSE

	Information	Referrals	Women-only counsel	Agencies	Other	No	No response	TOTALS
TOTALS	28	35	13	12	7	1	2	98
NORTH	8	7	5	5	0	0	2	27
URBAN	18	23	7	4	6	0	0	58
RURAL	2	5	1	3	1	1	0	13

G. IF A WOMAN IS IDENTIFIED AS A VICTIM OF SEXUAL ABUSE DURING TREATMENT, WHAT IS YOUR AGENCY'S RESPONSE?

H. DO YOU PROVIDE PROGRAMS SENSITIVE TO SPECIAL NEEDS WOMEN?

( ) agency accessible by wheelchair
( ) bathrooms accessible by wheelchair
( ) interpreters for hearing impaired clients
( ) allow women to continue psychotropics drugs
( ) literacy support for the learning-disabled
( ) technological supports
( ) other -- please explain

TABLE 14H
SERVICES TO IMPROVE ACCESSIBILITY

	WC	WC Bath	Interpreter	Drugs	Literacy	Tech support	Other	No	No response	TOTALS
TOTALS	22	19		18	11	5	6	3	9	102
NORTH	3	2		3	2	2	1	2	3	21
URBAN	15	13		14	9	3	4	0	5	68
RURAL	4	4	1	1	0	0	1	1	1	13

I. WHAT IS YOUR AGENCY'S RESPONSE TO A SPECIAL NEEDS WOMAN SEEKING TREATMENT?

J. DO YOU PROVIDE PROGRAMMING SENSITIVE TO THE NEEDS OF LESBIAN WOMEN?

( ) information on the range of human sexuality
( ) refer to those dealing with a specifically lesbian clientele
( ) other -- please explain

TABLE 14
SERVICES FOR LESBIAN & BISEXUAL WOMEN

	Information	Referrals	Other	No	No response	TOTALS
TOTALS	16	4	6	4	7	37
NORTH	2	0	4	2	2	10
URBAN	12	4	1	1	5	23
RURAL	2	0	1	1	0	4

K. WHAT IS YOUR AGENCY'S RESPONSE TO A WOMAN WHO IDENTIFIES HERSELF AS LESBIAN DURING TREATMENT?

L. DO YOU PROVIDE PROGRAMMING SENSITIVE TO THE NEEDS OF WOMEN WHO REFLECT CULTURAL AND SPIRITUAL DIVERSITY?

( ) access to interpreters
( ) spiritual advisers of the client's choice
( ) information regarding immigration laws
( ) sensitivity to dietary customs
( ) other -- please explain

TABLE 14.
SERVICES REFLECTING CULTURAL & RELIGIOUS DIVERSITY

	Interpreters	Spiritual Advisors	Information	Diet	Other	No	No response	TOTALS
TOTALS	14	23	7	15	5	4		68
NORTH	6	6	2	4	0	2	1	1
URBAN	6	13	5	10	4	1	6	39
RURAL	2	4	0	1	1	1	1	9

M. WHAT IS YOUR AGENCY'S RESPONSE TO THE NEEDS OF WOMEN WHO REFLECT SPIRITUAL AND CULTURAL DIVERSITIES?

16. HOW DOES YOUR AGENCY RESPOND GENERALLY TO THE NEEDS OF WOMEN?

( ) women only counselling
( ) feminist counsellor on staff
( ) information on women's issues
( ) other -- please explain

TABLE 16
AGENCY RESPONSE TO WOMEN'S NEEDS

	Women-only counsel	Feminist Counsel	Information	Other	No response	TOTALS
TOTAL	19	10	28	7	5	69
NORTH	5	1	9	2	1	18
URBAN	13	8	15	4	3	43
RURAL	1	1	4	1	1	8

PART TWO: CONFIDENTIAL

A RECENT REPORT MADE SEVERAL RECOMMENDATIONS REGARDING THE NEEDS OF WOMEN WHO EXPERIENCE PROBLEMS WITH DRUG AND ALCOHOL USE.
WE'D LIKE YOUR OPINION ON THESE RECOMMENDATIONS.

ESSENTIALLY, THE REPORT SAID THERE IS A NEED FOR PROGRAMMING SPECIFIC TO WOMEN.
WE'D LIKE TO KNOW WHAT YOU THINK.

AN ANALYSIS OF THE INFORMATION YOU PROVIDE WILL BE CONTAINED IN A REPORT, SEPARATE FROM THE DIRECTORY BUT INTENDED FOR GENERAL DISTRIBUTION.

YOUR COMMENTS WILL BE TREATED ANONYMOUSLY AND WILL NOT BE ATTRIBUTED TO YOU.
YOUR OPINIONS WILL BE REFLECTED IN THE REPORT BUT AGGREGATED TOGETHER WITH THOSE OF OTHER RESPONDENTS.

PLEASE FEEL FREE TO USE THE MARGINS OR BACK PAGES FOR ADDITIONAL COMMENTS.

REPORT CONCLUSIONS AND RECOMMENDATIONS

1. THE NEEDS OF WOMEN EXPERIENCING PROBLEMS WITH ALCOHOL AND DRUG USE ARE DIFFERENT FROM THOSE OF MEN. WHAT DO YOU THINK?

1	2	3
Disagree Strongly	Agree Somewhat	Agree Strongly

TABLE 1-ATTITUDES

	Disagree Strongly	Agree Somewhat	Agree Strongly	No Response	TOTALS
TOTALS	3	24	14	1	42
NORTH	3	6	2	0	11
URBAN	0	12	12	0	24
RURAL	0	6	0	1	7

2. THE STUDY RECOMMENDS THAT CHILDCARE BE ACCESSIBLE TO WOMEN WHO NEED IT. WHAT DO YOU THINK - AND WHY?

1	2	3
Disagree Strongly	Agree Somewhat	Agree Strongly

TABLE 2-ATTITUDES

	Disagree Strongly	Agree Somewhat	Agree Strongly	No Response	TOTALS
TOTALS	2	7	30	3	42
NORTH	2	1	8	0	11
URBAN	0	2	20	2	24
RURAL	0	4	2	1	7

3. THE STUDY RECOMMENDS THAT PROGRAMS SHOULD ADDRESS THE NEEDS OF ABORIGINAL WOMEN. WHAT DO YOU THINK - AND WHY?

1	2	3
Disagree Strongly	Agree Somewhat	Agree Strongly

TABLE 3-ATTITUDES

	Disagree Strongly	Agree Somewhat	Agree Strongly	No Response	TOTALS
TOTALS	1	10	29	2	42
NORTH	0	1	10	0	11
URBAN	0	5	18	1	24
RURAL	1	4	1	1	7

4. THE STUDY RECOMMENDS THAT PROGRAMS NEED TO ADDRESS THE ISSUES CONCERNING WOMEN WHO HAVE BEEN SEXUALLY ABUSED, AS ADULTS OR CHILDREN. WHAT DO YOU THINK - AND WHY?

1 Disagree Strongly 2 Agree Somewhat 3 Agree Strongly

TABLE 4-ATTITUDES

	Disagree Strongly	Agree Somewhat	Agree Strongly	No Response	TOTALS
TOTALS	1	8	31	2	42
NORTH	0	1	10	0	11
URBAN	0	6	17	1	24
RURAL	1	1	4	1	7

5. THE STUDY RECOMMENDS THAT PROGRAMS NEED TO ADDRESS WOMEN'S NEEDS AS THEY RELATE TO FAMILY VIOLENCE. WHAT DO YOU THINK - AND WHY?

1 Disagree Strongly 2 Agree Somewhat 3 Agree Strongly

TABLE 5-ATTITUDES

	Disagree Strongly	Agree Somewhat	Agree Strongly	No Response	TOTALS
TOTALS	1	5	32	4	42
NORTH	0	1	10	0	11
URBAN	0	2	19	3	24
RURAL	1	2	3	1	7

6. THE STUDY RECOMMENDS THAT PROGRAMS NEED TO BE RESPONSIVE TO THE ECONOMIC REALITIES OF WOMEN'S LIVES. WHAT DO YOU THING - AND WHY?

1 Disagree Strongly 2 Agree Somewhat 3 Agree Strongly

TABLE 6-ATTITUDES

	Disagree Strongly	Agree Somewhat	Agree Strongly	No Response	TOTALS
TOTALS	1	12	24	5	42
NORTH	0	2	9	0	11
URBAN	0	6	15	3	24
RURAL	1	4	0	2	7

7. THE STUDY RECOMMENDS THAT THERE IS A NEED FOR SERVICES TO ACCOMMODATE WOMEN WITH SPECIAL NEEDS. WHAT DO YOU THINK - AND WHY?

1 Disagree Strongly 2 Agree Somewhat 3 Agree Strongly

TABLE 7-ATTITUDES

	Disagree Strongly	Agree Somewhat	Agree Strongly	No Response	TOTALS
TOTALS	2	9	26	5	42
NORTH	0	2	8	1	11
URBAN	0	5	16	3	24
RURAL	2	2	2	1	7

8. THE STUDY RECOMMENDS THAT PROGRAMS NEED TO BE RESPONSIVE TO LESBIANS. WHAT DO YOU THINK - AND WHY?

1 Disagree Strongly 2 Agree Somewhat 3 Agree Strongly

TABLE 8-ATTITUDES

	Disagree Strongly	Agree Somewhat	Agree Strongly	No Response	TOTALS
TOTALS	4	16	14	8	42
NORTH	0	3	5	3	11
URBAN	2	9	9	4	24
RURAL	2	4	0	1	7

9. THE STUDY RECOMMENDS THAT PROGRAMS NEED TO REFLECT THE NEEDS OF WOMEN WHO REPRESENT CULTURAL OR RELIGIOUS DIVERSITIES. WHAT DO YOU THINK - AND WHY?

1 Disagree Strongly | 2 Agree Somewhat | 3 Agree Strongly

TABLE 9-ATTITUDES

	Disagree Strongly	Agree Somewhat	Agree Strongly	No Response	TOTALS
TOTALS	4	11	21	7.38	43.38
NORTH	0	2	8	1	11
URBAN	2	6	12	4	24
RURAL	2	3	1	2.38	8.38

10. THE STUDY RECOMMENDS THAT WOMEN NEED A SAFE ENVIRONMENT WHERE THEY CAN COME TOGETHER AND OPENLY DISCUSS THEIR EXPERIENCES.. WHAT DO YOU THINK - AND WHY?

1 Disagree Strongly | 2 Agree Somewhat | 3 Agree Strongly

TABLE 10-ATTITUDES

		Agree Somewhat	Agree Strongly	No Response	TOTALS
TOTALS	0	5	34	3	42
NORTH	0	0	10	1	11
URBAN	0	3	20	1	24
RURAL	0	2	4	1	7

11. WHAT OTHER RESOURCES DO YOU THINK WOULD HELP WOMEN WHO HAVE PROBLEMS WITH SUBSTANCE USE?

12. WHO IS OR WHO SHOULD BE PROVIDING THESE RESOURCES?

13. DO YOU THINK THE FAMILY AND COMMUNITY SHOULD HAVE AN ACTIVE ROLE TO PLAY IN THE HEALING PROCESS OF WOMEN WITH ALCOHOL AND DRUG PROBLEMS?

14. IF SO, WHAT APPROACH WOULD YOU RECOMMEND TO ENSURE THAT THIS HAPPENS?

15. ARE THERE ANY OTHER ISSUE OF CONCERNS OR COMMENTS THAT YOU THINK WE SHOULD KNOW ABOUT?

16. WOULD YOU LIKE TO RECEIVE A COPY OF THE FOLLOWING:

( ) the resource directory
( ) the report

APPENDIX 3

WOMEN'S STORIES & INTERVIEW QUESTIONS

The stories listed are examples of the twenty-nine stories told during interviews. Each story provides a brief biographical sketch of five women interviewed for this report. All names have been changed to protect the anonymity of the women who participated. The questions used in the interview process are listed after the five stories.

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SHANNON

Shannon is a twenty-seven year old Aboriginal woman. She has one child. She is presently living common-law with her child's father. He attends classes while she stays at home with the baby. They live on Social Assistance.

Shannon first began drinking at a young age because of peer-pressure; basically looking for a good time; something to cover the hurt she felt. In a previous five year relationship, she was physically abused. She had to drink when he did whether she wanted to or not. This relationship ended when she was twenty-two.

After the break-up, Shannon drank heavily for two years. During this time she was forced to leave home by her father. Her father sent her out to "try and make it on her own." This left her lonely and very lost.

In November of 1991, her father committed suicide. She found his body. Her mother had also died in violent circumstances - murder.

Shannon has gone through a lot since early childhood. She was the responsible one in an alcoholic home. She parented the rest of the children. Still, today, her siblings lean on her for support. Their separations when placed in foster homes were very difficult and upsetting for Shannon. She still speaks about the hurt she feels from the abuse she endured, also from all the abuse she knew her brothers and sisters suffered in these homes.

Today, Shannon finds it very difficult to relate to women because of an alcoholic mother who left the family while they were still very young. In order for her to trust and relate, she has to see the genuine caring of the women. Shannon has successfully dealt with a lot of her personal and family issues. She has accomplished this through counselling.

****

KAMILLA

Kamilla is a twenty-four year old Caucasian. She is a single parent living on Social Assistance and attending upgrading. She has an eight year old son. She grew up in a single parent family, never meeting her father. Her family has a history of problematic substance use. She survived all forms of abuse; physical and emotional abuse from her mother, and was sexually abused by an uncle and later, family friends.

She began using alcohol on a regular basis at age eleven. A year later she began to use other drugs. She dropped out of school at age fifteen, just prior to giving birth to the son.

At age eighteen she admitted herself to the psychiatric ward of a local hospital, where she was placed on drug therapy. After not seeing her doctor since she was admitted, six days earlier, she decided to leave. She was threatened with electro-shock therapy if she insisted on leaving, but choose to leave regardless.

That same year she entered detox and then began attending A.A. & N.A. meetings. She had difficulty with the concept of an omnipotent higher power, and stated that she wasn't being accepted by her continuing care group. She also felt the notion of never using substances again, meant that the substances still exercised control over her. Based on these concerns, she stopped participating in continuing care.

She maintained a period of sobriety, during which time she sought counselling at Family Services Bureau, the local Mental Health Clinic and through the Contemporary Women's program.

Today she feels that her substance use is no longer problematic and defines herself as a social user.

****

NICOLE

Nicole is a twenty-nine year old Metis woman who identifies as a lesbian. She grew up in an alcoholic family, with her mother going in and out of recovery. At age seven, her parents divorced. She was sexually abused as a child by family members including cousins, uncles and two brothers. She was physically abused by one brother, and suffered emotional abuse.

She started using at age fourteen. Her drug of choice was primarily alcohol. Although she used other drugs, she does not view their use as problematic in comparison to the alcohol.

She stopped drinking at age twenty-eight after physically abusing her partner resulting in the ending of the relationship. She attended out-patient treatment for three weeks, and attended A.A. meetings for four months. She stopped attending because she felt she couldn't be open at the meetings, a similar difficulty to the one she faced during treatment.

Today, after one year of sobriety, she credits her sobriety with giving her the confidence to take advantage of the many opportunities that life is presenting her.

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RACHEL

Rachel is a fifty year old Caucasian woman and a single parent with three children. Born the middle child in a family with three children, Rachel trained as a nurse after graduating from high school. There is no history of substance use or any kind of abuse in Rachel's family, although she notes that she had difficulty remembering her past life, particularly her childhood.

Rachel began using alcohol as a teenager. She married at a young age after an unexpected pregnancy. During her marriage she took anti-depressants and tranquillizers. Her second child was born addicted to Phenobarb. After separating from her husband, Rachel began to use codeine. Her doctor finally refused to prescribe more tranquillisers. Between 1972 and 1974, Rachel underwent surgery four times and became addicted to Demoral and Gravol.

When she went to see her doctor, she was prescribed Librium to help her cope with difficulties she was having managing a single parent household. She began to also take sleeping pills and while working at the hospital, would take medications from the common bottles [bottles that were used by all patients]. During this time she was also drinking. She identifies herself as a triple user: food, medications and alcohol.

In mid-1974 she decided to seek help for her problematic substance use and after calling a friend, had two A.A. members come to her home that night and "12-step" her. She has remained active within A.A. since that initial contact.

Today Rachel lives with a physical disability that affects her mobility. She has been sober for almost twenty years and is now working towards a holistic and healthy lifestyle.

****

KAREN

Karen, an Aboriginal woman, was born in 1956, the oldest of six children. Her family has a history of problematic substance use. She identifies a number of problems within her family of origin; first problematic substance use and then, physical, sexual and emotional abuse.

She began using at age thirteen. Her drugs of choice were alcohol and inhalants.

Today, her mother continues to have problems related to substance use, but Karen and one sister are both in recovery. Karen, who has five children, decided that she wanted something different for them than what she experienced as a child. Based on this decision she sought out services to assist her in her recovery.

She has attended two detox centres, and four different treatment centres during the course of her recovery, and is now active within a support group as part of her continuing care. Her experience has been that racism is present within many of the treatment and continuing care programs, but credits a network of friends as a positive support system to draw strength from.

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Interview Questions

1. Please give us some biographical information on yourself.

2. What made you look for help?

3. Where did you go for help? or What help did you seek?

4. Were you helped? In what way?

5. What was helpful? What helped you most?

6. What wasn't helpful? or Was there anything that bothered you about the help received or set you back in some way?

7. Is there anything you would have liked to have in the way of help and didn't receive?

8. What prevented you from getting that?

9. Women have told us that they need a safe place for dealing with alcohol and drug problems and talking about what is important to them. How important would that be for you?

10. Would you find it easier to relate to a male or female helping professional? Why?

11. What would you like to see in the way of help for women with problems with alcohol or drugs?

12. If you found a friend had a problem like yours, what would you do or say to help her? or What help would you recommend to her?

13. If you are/were in a relationship, what is/was your partner's attitude and behaviour toward the problem?

14. Is there anything else you would like to share with others about your experience?

15. What is the main message you would like to give women who are now experiencing the kinds of problems you had or have?

16. During you recovery process have you found anyone to have inappropriate expectations of you that were not part of the normal recovery process? (eg. 13 stepping)

17. Is there anything else you would like to add?

APPENDIX 4

LIST OF STEP PROGRAMS

The Twelve Steps of Alcoholics Anonymous

Alcoholics Anonymous(A.A.) is based on a twelve step program developed by Bill Wilson and Dr. Bob Smith. It is without a doubt the most popular and well-known recovery program available in North America. Formed in the late 1930's, the program was based on the experiences of one hundred men and one woman who had experienced problematic substance use (Kasl, 1992).

1. We admitted we were powerless over alcohol - that our lives had become unmanageable.

2. Came to believe that a Power greater than ourselves could restore us to sanity.

3. Made a decision to turn our will and our lives over to the care of God, as we understood Him.

4. Made a searching and fearless moral inventory of ourselves.

5. Admitted to God, to ourselves, and to another human being the exact nature of our wrongs.

6. Were entirely ready to have God remove all these defects of character.

7. Humbly asked Him to remove our shortcomings.

8. Made a list of all persons we have harmed, and became willing to make amends to them all.

9. Made direct amends to such people wherever possible, except when to do so would injure them or others.

10. Continued to take personal inventory and when we were wrong promptly admitted it.

11. Sought through prayer and meditation to improve our conscious contact with God as we understand Him, praying only for knowledge of His will for us and the power to carry that out.

12. Having had a spiritual awakening as the result of these steps, we tried to carry this message to alcoholics, and to practice these principles in all our affairs.

The Thirteen Affirmations of Women For Sobriety

Women For Sobriety (W.F.S.) was developed in 1976 by Dr. Jean Kirkpatrick, as an alternative to Alcoholics Anonymous (Kaskutas, 1992). The emphasis of this women-only step program is on self-empowerment. Continuing care groups that follow the W.F.S. Affirmations can be found throughout North America. As with A.A., W.F.S. produces recovery material in a number of different mediums, including video and tape cassette, books, brochures and newsletters (The Addiction Letter, October 1992).

1. I have a drinking problem that once had me.

2. Negative emotions destroy only myself.

3. Happiness is a habit I will develop.

4. Problems bother me only to the degree I permit them to.

5. I am what I think.

6. Life can be ordinary or it can be great.

7. Love can change the course of my world.

8. The fundamental object of life is emotional and spiritual growth.

9. The past is gone forever.

10. All love given returns two-fold.

11. Enthusiasm is my daily exercise.

12. I am a competent woman and have much to give life.

13. I am responsible for myself and my actions.

Feminist Model of the Twelve Steps

For along time, women, particularly survivors of childhood sexual abuse and other forms of abuse, have struggled with the language of the [A.A.] Twelve Steps. This feminist model of the Twelve Steps was birthed at the "Beyond Survival: Women, Identity & Addictions" conference held in Toronto in April of 1989. Sheri McConnell drafted the feminist model at the conference and has revised it a number of times over the past four years. The intention of this modified version is to prompt further discussion and to provide women with an alternate framework through which they can view recovery (McConnell, 1993).

1. Admitted that we have a problem and recognized that our social environment contributes to our problem.

2. Recognized that help is available and that there are other ways of coping.

3. Became willing to change and asked for help.

4. Looked at both our healthy and unhealthy behaviours and coping skills.

5. Broke the silence - shared our lives, our pain, and our joy with others.

6. Became teachable; became willing to learn new healthy behaviours to replace our unhealthy behaviours.

7. Began to forgive ourselves and others.

8. Became aware of and accepted responsibility for the harm we caused ourselves and others, recognizing that we do not need to take responsibility for those who harmed us.

9. Did what we could, without harming ourselves or others, to repair these damages and not repeat the unhealthy behaviour.

10. Took responsibility for our day to day behaviour recognizing both our healthy and unhealthy behaviours.

11. Developed our individual spirituality, seeking inner wisdom and strength.

12. As a result of ongoing healing and growth, we tried to live happier, healthier lives; learning to love and accept ourselves as we are; sharing our recovery with others.