days to six months or longer). Freestanding residential programs usually have treatment methods lasting 30 days to six months; quarterway houses (usually seven to 21 days long), and halfway houses (usually 14 to 60 days long, but which can last up to six months). It should be noted that these "typical" duration periods are frequently—if not primarily—driven by coverage decisions by third party payers (including Medicaid, Medicare, and private health insurance companies), rather than by standards of care set by the treatment community.

In its grant programs, CSAT tries to ensure that programs seek the optimum length of treatment necessary to meet the primary goal of recovery. Programs funded by CSAT—particularly programs serving pregnant and postpartum women and infants, and parenting women and their children—have longer terms of stay (six to 18 months). CSAT funds up to 12 months of residential treatment.

As with detoxification programs, residential treatment and rehabilitation services can include nursing care; individual, group, and family counseling; physical examinations (including laboratory tests); psychiatric evaluations; and provision of medications. For social service programs, medications are limited to clients with other health problems. These programs may include more comprehensive services such as employment counseling, referral for primary health care and social services, and referral of pregnant women for prenatal care. Therapeutic communities that are freestanding residential treatment programs use the social setting, drug-free treatment modality.

Outpatient detoxification services are less common than inpatient detoxification services. They are usually provided under the observation and supervision of trained treatment personnel to a client whose condition requires monitoring and observation for a period of time but does not require admission to an inpatient treatment facility. The services, which

usually last seven to 14 days, can include nursing and related care; individual, group, and family counseling; physical examinations (including laboratory tests); psychiatric evaluations; drug testing; and provision of medications (for detoxification and/or other health problems). During this period, the program may also arrange for outpatient follow-up care, either in the same facility or in another facility that offers outpatient treatment services. Outpatient detoxification services are provided through the following:

- medical facilities (not limited to hospitals), or
- freestanding programs that may or may not be independent of residential treatment programs.

Outpatient treatment services are programs in which clients may participate for widely varying periods (from 30 days to a year or more). More intensive outpatient programs may require visits totalling eight to 10 or more hours per week. Some hospital-based programs require hospitalization five days a week during daytime hours, or even daily, including weekends. Less intensive programs may require visits two or more times per week for individual counseling and participation in program-sponsored group counseling or 12-step meetings. Services usually include individual, group, and family counseling; employment counseling; and referral for health (medical and mental) and social (e.g., housing and Aid to Families with Dependent Children [AFDC]) services if not available in the treatment program itself. These programs are often affiliated with inpatient services and provide continuing care and follow-up services.

Self-Help/Support Groups. Mutual help or facilitated support groups such as Alcoholics Anonymous (AA) and Narcotics Anonymous (NA) are increasingly used by women recovering from alcoholism or other drug dependence. For example, women now comprise more than one-third

of AA participants. The involvement of women in self-help groups may be related in part to their convenience, which is an important attribute when the woman's motivation and possible roles as primary caregiver need to be considered.

As Covington notes:[6]

> mutual help groups...are free and, in most urban communities, readily available throughout most of every day...[they] are often found in women's centers or other places in communities that provide other types of help to women...[who] are permitted to come and go freely without records being kept or contracts drawn. Meetings occur as scheduled through cooperative efforts; they are dependable and consistent in their format.

Covington also notes that women "can use meetings for a variety of different purposes as well as staying sober. As a woman's needs shift in recovery, the meetings she attends may change to reflect this."[7] A particularly useful advantage of mutual self-help groups for the woman in continuing care is the fact that the meetings provide an opportunity for social activities that are alcohol-and drug-free.[8] Covington has also cautioned, however, that the 12-Step Model has limitations of which programs should be aware. These include, for example, the fact that "the ideology does not [necessarily] encourage attention to the relational, cultural, or sociopolitical factors that foster substance abuse in women... [and that] much of the AA literature was written 20-50 years ago and is overtly sexist in its content and connotations."[9] It should be pointed out that there is an increasing number of women's 12-step groups that are addressing the specific needs and circumstances of women.

Several of the CSAT Treatment Improvement Protocol (TIP) documents describe the use of support groups such as AA, NA, Women for Sobriety, and Rational Recovery in the treatment process. For example,

the TIP Assessment and Treatment of Patients with Coexisting Mental Illness and Alcohol and Other Drug Abuse[10] describes the use of support groups in sequential, parallel, and integrated approaches to addressing dual disorders. The TIP Pregnant, Substance Abusing Women,[11] describes the use of support groups in the context of comprehensive service delivery.

3.2.3 Treatment of Multiple Drug Use/Abuse

Since many individuals in substance abuse programs use more than one drug, programs are increasingly combining treatment for alcohol problems with treatment for other drug problems. For example, in 1990, of 7,743 treatment programs that received federal funds administered by the state alcohol and drug agency, 67.1 percent were combined alcohol and other drug treatment programs, 18.1 percent were programs exclusively for the treatment of alcoholism, and 14.9 percent were programs for the treatment of other drugs.[12] No gender disaggregated data were available.

3.3 Knowledge About Effective Treatment for Women

Gender-disaggregated data for treatment outcome continue to be relatively scarce, in spite of an expanded interest and a federal mandate to make such data available. Some descriptive data are available (e.g., proportion of clients who are women), and relatively more data are available for women in treatment for alcoholism. Outcome data from several federal data bases are forthcoming, and other studies that are specifically designed to determine treatment outcomes for women or that will provide gender-disaggregated data are currently underway.

The lack of gender-specific treatment outcome data hinders the valid design or adaptation of treatment methods specifically for women. Nonetheless, at least with respect to the treatment of alcoholism, the Institute of Medicine's earlier (1980s) research on treatment outcomes remains valid.

Quoting Braiker, the Institute notes that such research either failed "to distinguish between outcome rates for women and men or excluded [women] from the study sample altogether."[13] Although the data are minimal, those that exist, according to Blume and Roman, suggest the following:

> In general, in treatment for alcohol problems, males and females with comparable sociodemographic characteristics (marital status, employment, social stability, etc.) and at the same levels of problem severity appear to do equally well in the same treatment settings.[14]

Notably, however, Blume states that "what is not known are the components of treatment that would improve treatment outcome for both males and females."[15] In fact, few research studies have demonstrated the effectiveness of specific attributes of substance abuse treatment for any client, irrespective of gender. The experience of those who have provided treatment services for women in a variety of settings suggests that women have more successful outcomes when they receive gender-specific treatment for at least several months.[16]

The relative appropriateness of a particular method of treatment for women has not been determined. In fact, there has been little research on which to base any determination. The use of methadone is an established pharmacotherapy for the treatment of opioid addiction. However, its use as a treatment form has led to some degree of controversy. Examples of those who disagree with its use in the treatment of pregnant women are those who see methadone as only a replacement for heroin with another highly addictive substance. The CSAT Treatment Model states that:

The use of methadone is an established pharmacotherapy for the treatment of opioid addiction.

> pharmacotherapy intervention (e.g., methadone) should be provided on an as-needed basis and should include provision of, or established referral linkages, for concomitant assessment and monitoring by qualified medical or psychiatric staff.[17]

There is, however, no consensus in the field on the use of methadone in the treatment of pregnant women. CSAT's TIP document, Pregnant, Substance-Using Women, recommends methadone maintenance combined with psychosocial counseling and medical services for pregnant opioid-addicted women. The primary reason for this recommendation is that the fetus is also dependent on the opioid and could be spontaneously aborted if the woman is no longer taking the opioid and the fetus has withdrawal symptoms in utero. The physician prescribes as small a methadone dosage as possible to help ensure that the fetus can be born. After the birth, the physician provides medical assistance to help the mother and child withdraw from the drug(s).

In the treatment of pregnant heroin-addicted women, according to CSAT's 1992 report, State Methadone Maintenance Treatment Guidelines, "methadone maintenance by itself is not necessarily sufficient to reduce perinatal complications."[18] In its 1993 update of that document, CSAT suggested that for pregnant women who are enrolled in programs that use methadone to treat heroin addiction, methadone "must be offered in conjunction with prenatal care reinforced by psychosocial counseling and other medical services."[19] Importantly, CSAT notes that pregnant women who received methadone prior to pregnancy can initially be maintained on their prepregnancy dose, but those who did not receive methadone prior to pregnancy should receive inpatient care for a general and obstetrical assessment, a determination of their physiologic dependence on heroin and other drugs, and to initiate their methadone treatment.[20]

Treatment of pregnant women at the point of withdrawal from crack or cocaine is a particular problem, and, as CSAT has noted, "The evidence is extremely limited for all methods of medical withdrawal." Although inpatient or residential treatment is "the ideal whenever possible... these facilities may not always be available."[21]

The lack of adequate data and information in the field of women and substance abuse treatment underscores the need for more research on the effectiveness of various treatment approaches for women. For example, in a 1993 study of the accessibility, relevancy, and validity of published literature concerning minority women and substance abuse, a thorough search of the literature revealed only 200 relevant articles, of which only 92 were research-based.[22] Thus, in spite of longstanding purported interest on the part of the public health community and widespread media attention to such problems as babies born to crack cocaine-using women, only limited funds have been made available for research to design an effective program specifically for substance abusing women.

The lack of adequate data and information in the field of women and substance abuse treatment underscores the need for more research on the effectiveness of various treatment approaches for women.

3.3.1 Critical Components of Treatment for Women

In its Comprehensive Treatment Model, CSAT recommends that the following services, among others, be provided either on-site or through referral as part of the treatment process:[23]

Medical Interventions

- testing and treatment for infectious diseases, including hepatitis, TB, HIV, and STDs.
- screening and treatment of general health problems, including anemia and poor nutrition, hypertension, diabetes, cancer, liver disorders, eating disorders, dental and vision problems, and poor hygiene.
- obstetrical and gynecological services, including family planning, breast cancer screening, periodic gynecological screening (e.g., pap smears), and general gynecological services.
- infant and child health services, including primary and acute health care for infants and children, immunizations, nutrition services (including assessment for Women, Infants, and Children (WIC)

program eligibility), and developmental assessments performed by qualified personnel.

Substance Abuse Counseling and Psychological Counseling

- counseling regarding the use and abuse of substances directly, as well as other issues which may include low self-esteem, race and ethnicity issues, gender-specific issues, disability-related issues, family relationships, unhealthy interpersonal relationships, violence, including incest, rape, and other abuse, eating disorders, sexuality, grief related to loss of children, family, or partners, sexual orientation, and responsibility for one's feelings including shame, guilt, and anger.

- parenting counseling, including information on child development, child safety, injury prevention, and child abuse prevention.

- relapse prevention, which should be a discrete component or phase of each woman's recovery plan.

Health Education and Prevention Activities

- health education and prevention activities should cover the following subjects: HIV/AIDS, the physiology and transmission of STDs, reproductive health, preconception care, prenatal care, childbirth, female sexuality, childhood safety and injury prevention, physical and sexual abuse prevention, nutrition, smoking cessation, and general health.

Life Skills

- education should include practical life skills, vocational evaluation, financial management, negotiating access to services, stress management and coping skills, and personal image building.

- parenting, including infant/child nutrition, child development, and child/parent relationships.

- educational training and remedial services should be provided with access to local education/GED programs and other educational services as identified at intake.
- English language competency and literacy assessment programs should be facilitated.
- job counseling, training, and referral should be provided, if possible, via case managed/coordinated referrals to community programs.

Other Social Services

- transportation for clients to gain access to substance abuse treatment services and related community services.
- child care.
- legal services.
- housing.

It is important that all treatment components be accessible to all women. This may entail making accommodations for women with disabilities and for older women. Chapters 4, 5, and 6 detail strategies related to these types of services in the outreach/identification, comprehensive treatment, and continuing care/follow-up phases of treatment, respectively.

3.4 Case Management

Case management is a critical component of any substance abuse treatment program. For programs that provide comprehensive treatment services which require accessing and coordinating numerous sources of such services and which involve multiple disciplines of different care providers, it is imperative. The International Certification Reciprocity Consortium/Alcohol and Other Drug Abuse, Inc. (ICRC/AODA) has defined case management to include the following:

> ...activities which bring services, agencies, resources, or people together within a planned framework of action toward the achievement of established goals. It may involve liaison activities and collateral contacts."[24]

Case management should be an integral part of the treatment process, from the point of intake through continuing care. In describing practical aspects of case management in the treatment of alcohol and other drug disorders, Kulewicz suggests that:

> In the treatment process, either inpatient or outpatient, the basic concepts remain the same. Effective treatment is contingent upon a cooperative effort of the client and the treatment staff. The treatment staff usually consists of the primary counselor, counselor, clinical supervisor, staff psychologist, and consulting psychiatrist. It is not unusual to include the staff physician and/or nursing staff member in those cases where it is appropriate to meet the individual client's needs. The interacting and consulting efforts on the part of the team enable the treatment process to be continually monitored and updated on an ongoing, regular basis.[25]

Effective treatment is contingent upon a cooperative effort of the client and the treatment staff.

In treatment programs serving women, especially those offering comprehensive services, the client's records—including for example the treatment plan, the counselor's notes and those of other treatment providers, and follow-up forms from programs to which the client has been referred—form the basis for case management. These records must be current and complete, reflecting the full range of services provided to the client and the full range of her needs. Additional information regarding the client should be discussed during periodic case management conferences (usually held weekly), and any determinations made on the basis of this conference should be recorded in the client's file.

Examples of the application of case management techniques are provided in Chapters 4, 5, and 6.