Chapter 4

Outreach To and Identification of Women

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Program directors and administrators must understand and accept the importance of customized outreach that uses gender-specific strategies.

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Although there is growing awareness, understanding, and acceptance among health professionals and the public that alcoholism and other drug addictions are major public health issues, negative attitudes and misconceptions concerning women and substance abuse still abound. These attitudes and misconceptions often pose silent barriers to treatment for women. Women with substance abuse problems are often reluctant to admit their need for treatment. They may fear social rejection or loss of their children or they may have internalized the prevailing social attitudes toward addiction. Furthermore, for many women, poverty and related socioeconomic conditions, often compounded by discrimination based on race, psychiatric disorders, ethnicity, disability, sexual orientation, and/or age, create additional problems that may further inhibit them from seeking treatment.

A woman who needs treatment for a substance abuse problem may be deterred by the relative lack of treatment services designed specifically for women. Women with children may be discouraged by the shortage of treatment services that include provisions for child care if they must leave their children in unreliable hands to enter treatment. A successful outreach program must recognize these factors as barriers to treatment and ensure that the treatment program addresses them.

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To develop an outreach program for women with substance abuse problems, it is important to acknowledge that substance abusing women are represented in all ages, races, cultures, ethnic groups, educational levels, and socioeconomic status, as described in Chapter 2. To be successful, outreach efforts must recognize these differences and target specific populations.

This chapter addresses these issues by:

- describing barriers to outreach and treatment;
- describing barriers to outreach and treatment for specific population groups; and
- presenting general approaches to outreach.

4.1 Barriers to Outreach and Treatment

Women often confront barriers to finding, entering, and completing substance abuse treatment programs. Society imposes some of the barriers. Others are internal within the woman herself. Some barriers are unique to special populations, but many are relevant to women of different ages, races, and socioeconomic status. There are generally three types of barriers:

- Generic, systemic barriers that are not gender-specific (e.g., racism, classism, aversion to behavior perceived as "deviant," lack of community-based social support services);
- Gender-specific barriers (e.g., lack of geographically accessible treatment services for women; lack of child care); and
- Internalized reaction to either the generic or gender-specific barriers, or other individual experiences or issues faced by an individual woman (e.g., the client's belief that she is indispensable and cannot leave home to seek treatment).

In practice, specific barriers often cross these general types. Barriers that cut across different populations are in this section; those that are unique to special populations are presented in Section 4.3.

Economic inequality. Women earn $0.70 for every $1.00 earned by men, are much more likely to be single heads of households, and are much

more likely to live in poverty. The cost of treatment may be a significant obstacle for uninsured and low income women who need treatment for substance abuse and its related problems.

By the end of 1993, nearly 40 million Americans had no health insurance. In 1989, the most recent year for which gender breakdowns of uninsured Americans are available, 15 percent of American women had no health insurance coverage (compared with 16 percent of men) and 7.6 percent of women were covered by Medicaid (compared with 5.2 percent of men).[1] Women who are insured by programs such as Medicaid often find it difficult to locate a program that will accept this type of payment.

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Furthermore, even if a woman has insurance, it may not cover alcohol or other drug treatment, or there may be limits to either the setting of care or the number and types of services (e.g., detoxification days or therapy sessions that may be covered in a lifetime). The coverage or entitlement program may also require a co-payment that the woman cannot afford. Because of the lower incomes of women in comparison to men, health insurance factors significantly affect financial access to care.

Social Stigmatization. Women who have substance abuse problems are often perceived as less "socially acceptable" than their male counterparts. They are, therefore, less likely to disclose their need for treatment and more likely to have sustained periods during which substance abuse is not diagnosed or is misdiagnosed. In our society a substance-abusing woman is often considered a second-class citizen. She may also be seen as sexually promiscuous and weak-willed because of her alcohol and other drug abuse.[2] Social stigma exacerbates denial, a primary barrier to outreach. Outreach workers need to engage women in discussions that will overcome the psychological and emotional results of social stigma.

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In certain cultures, the fear of social stigmatization may be particularly strong. For example:

> Women of color [who abuse alcohol] share a double stigma as alcoholics and as minority women. For a woman of color who is also lesbian, the stigma and isolation is further compounded. Women of color are usually alone or in a small minority in either minority programs dominated by men or women's programs dominated by Caucasian women.[3]

Thus, women of color experience many layers of stigmatization: gender, race/ethnicity, culture, and substance abuse.

Lack of Social and Emotional Support. Women generally encourage men who have substance abuse problems to enter treatment. However, women's partners, family members, and friends often enable women to continue their substance abuse by denying the existence of the problem or its seriousness rather than encouraging them to seek treatment. Women are more likely to bear the primary responsibility for care of their family members, in part because they are four times as likely as men to be the head of a single parent household with children. Therefore, women face practical considerations surrounding a decision to enter treatment, especially inpatient or residential care, that men do not confront as frequently.

Prisons for men are more likely to have medical services, substance abuse treatment, and other support services than are those for women.

Lack of Institutional Mechanisms to Help the Substance-Abusing Woman. Institutional mechanisms that identify and sometimes help men with substance abuse problems are not as readily available as outreach vehicles to women. For example, women who need treatment are less likely than are men to be identified in the workplace because proportionally fewer are employed (63 percent of women were employed in 1990 in comparison to 75 percent of men).[4] Although the number of adolescent girls and adult women in the criminal justice system is increasing (there has

been a 200 percent increase in the women's prison population in the past 8 years), prisons for men are more likely to have medical services, substance abuse treatment, and other support services than are those for women. However, women have more contact with staff from social services (welfare), Head Start, shelters, hospitals (when giving birth), and emergency rooms (when battered). The personnel employed by these institutions need to be trained to identify substance-abusing women.

Cultural Values and Norms. Until fairly recently, cultural differences have been largely ignored in addressing treatment issues. Today, it is understood that to treat women with substance abuse problems successfully a program must have a certain level of "cultural competency."

Culture, as defined in *Cultural Competence for Evaluators*, is the shared values, norms, traditions, customs, arts, history, folklore, and institutions of a group of people. Within this perspective and from this definition, cultural competence is a set of academic and interpersonal skills that allow individuals to increase their understanding and appreciation of cultural differences and similarities within, among, and between groups. This requires a willingness and ability to draw on community-based values, traditions, and customs, and to work with knowledgeable persons of and from the community to develop focused interventions and other supports.[5]

As Orlandi has noted,

> Cultures do not remain the same indefinitely. Cultural subgroups exert an influence over and are influenced by individuals who are members of those groups as well as other cultural groups with whom these subgroups come into contact.[6]

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> Women of color fear not only outright racism but a treatment system insensitive to their cultural and ethnic values which may also have little sensitivity to the special needs of women...[7] The culturally liberated caregiver acknowledges the reality of racism without allowing it to be an excuse for the client's self-destructive behavior.[8]

This can apply to other populations as well, including lesbians, women with disabilities, and women who have been or are prostitutes.

Family Responsibilities. Many women will not enroll in outpatient treatment programs unless they can arrange adequate supervision for their children. Women entering inpatient treatment who leave their children in someone else's care may fear losing custody of their children. This is particularly true for the following women:

- women already in the criminal justice system who believe disclosure of a substance abuse problem will be the "last straw" as far as custody is concerned;
- pregnant women who fear being called "unfit mothers" or facing legal sanctions for using drugs while pregnant;
- women subjected to domestic violence who fear that no one will protect their children;
- homeless women who fear that Child Protective Services will remove their children from their custody;
- lesbians who are concerned that disclosure of their lifestyle will result in losing custody of their children;

- women with disabilities who, even without the stigma of substance abuse, are often perceived as unable to fulfill the parenting role; and

- any woman with children who does not have a family or support system to care for her children while she is in treatment.

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The treatment program staff should be aware that the degree of fear experienced by these women (expressed or not) may depend on the cultural "value" placed on children and the role of children in the family.

Thus if a program does not provide child care, neither inpatient nor outpatient treatment is truly available to women with children, who are the majority of substance abusing women. To attract women with children, the treatment program should do at least one of the following:

- investigate and evaluate the possibility of providing full or partial child care on the premises during the mother's treatment process and meet the necessary licensing requirements for providing such care;

- recruit volunteers among program staff, women in the final stages of treatment, family members, retired persons or senior citizens, interns from local schools and places of worship, and members of self-help groups to staff the child care program; and

- compile and distribute a directory of free or low-cost licensed day care service providers in the community and explore financial subsidies to improve access.

Denial. Denial is a primary characteristic of addiction. Outreach programs may, in fact, be the first step in helping a woman break through denial. Reaching out to a woman and engaging her in a process of acknowledging a need for help is a prerequisite for effective treatment. A

woman who acknowledges that she needs help is much more empowered to accept and remain in treatment.

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Women's Fears. Substance-abusing women have many fears that must be addressed in designing and implementing outreach strategies. These include the following:

Fear of Rejection. Many women live in great fear of being rejected and abandoned by loved ones, friends, and by others, for example co-workers. They believe their loved ones may reject them if they learn that their mother, spouse, daughter, partner, friend, or sibling is addicted to alcohol and/or other drugs. Some adolescent girls and adult women also believe that a treatment program or its staff will reject them. They may fear rejection because they are "too bad," they engage in life styles not approved of by society.

Fear of rejection may be particularly pronounced among adolescents, especially those in the criminal justice system, whose families may have already rejected them. Also, women with AIDS or women who are HIV-positive may fear rejection if they have already felt rejected by health care providers, employers, family, and friends once they revealed their medical status.

Fear of Becoming Abstinent or Getting Well. For women who have developed few if any coping skills (e.g., assertiveness skills, stress management techniques), the idea of facing life without the temporary relief and/or escape that alcohol and other drugs offer at least in the early stages of use may be overwhelming. During the outreach phase, these women need assurance that it is possible not only to face life but to enjoy it without the "help" of mood-altering or mind-altering chemicals. Using recovering women as role models in the outreach program can provide this