Women may have residual disabilities from their abuse of alcohol and other drugs that may not be taken into account by vocational and educational programs to which they may be referred. Women may be routed into short-term, low-paying clerical or other jobs while they still cannot read, write, concentrate, or coordinate eye-hand movements because of the aftereffects of drugs on the central nervous system. These effects may take a while to abate after a client becomes abstinent. Some women may need to be classified as "long-term disabled" to ensure they receive prolonged recovery treatment and continued care.

Women may have residual disabilities from their abuse of alcohol and other drugs that may not be taken into account by vocational and educational programs to which they may be referred.

Child Care and Parenting Skills. Women in continuing care may need assistance to develop strong, nurturing relationships with their children and to access child care before and after discharge from treatment. Treatment programs can help women develop strong parenting skills and find appropriate child care in the following ways:

Women in continuing care may need assistance to develop strong, nurturing relationships with their children.

- support a woman's desire to be a full-time parent, if assessment shows she is able and prepared to assume the full-time care of a young child or of several children;
- continue to provide counseling and support or referrals for these services to women who feel they cannot cope with parenting and/or who believe that their children would be better off in the care of someone else;
- ask for assistance from the Center for Substance Abuse Treatment, the state or county office responsible for child and family services, or a local university to help develop a parenting curriculum for mothers in recovery;
- develop a resource directory of parenting assistance and child care agencies, foster home systems, private homes, nurseries, and schools in collaboration with a family service agency; and

- investigate community-sponsored parenting and child care courses that are free or inexpensive and invite existing programs to provide their courses to clients on-site, if possible.

6.1.4 Provisions for the Terminally Ill

Until recently, services for women who are terminally ill were not considered part of continuing treatment. The advent of HIV/AIDS in communities with a high incidence of substance abuse has made this an urgent need. Continuing care for addicted women in terminal stages of any disease includes providing food, shelter, clean bedding, and clothing, access to personal hygiene facilities, assistance in addressing "unfinished business," compassionate interaction, and assistance in accessing spiritual guidance. The facility in which terminally ill clients are housed must be safe (insofar as possible) and clean, and must have room for women to visit with their children. HIV/AIDS support groups, Alcoholics Anonymous, Narcotics Anonymous, and other 12-Step programs should be made available on-site.

The substance abuse treatment program staff need to work closely with hospice program staff and with child protective services to keep families intact, if possible and appropriate. Funding possibilities for hospice care include charitable organizations such as the United Way, churches and synagogues, health insurance companies, private foundations, women-owned businesses, and county health departments.

6.1.5 Women with Dual Disorders

In addition to the general discussion of the prevalence of dual disorders among substance-abusing women (Chapter 2), issues related to assessment and treatment of women with dual disorders are described in

Chapters 3, 4, and 5. For those women who have dual disorders, the period of continuing care following structured treatment can be particularly difficult. Because formal substance abuse treatment seldom lasts long enough to address such problems thoroughly, women with dual disorders need continuing treatment not only for the substance abuse problem, but often (and as importantly) for the dually-diagnosed disorder as well. This is true whether or not the disorder is directly related to the problem of substance abuse (see discussion in Chapter 3).

For those women who have dual disorders, the period of continuing care following structured treatment can be particularly difficult.

To help ensure that the needs of the client with a dual disorder (or disorders) are met, the treatment program staff should prepare a mental health assessment for each client prior to discharge, make referrals for continuing mental health services, and arrange for follow-up on the outcome of these services, insofar as possible. The CSAT report, Assessment and Treatment of Patients with Coexisting Mental Illness and Alcohol and Other Drug Abuse advises programs that:

> An aftercare plan for patients with dual disorders is essential. This plan should integrate rather than fragment strategies for treating the patient. It should include methods to coordinate care with other treatment providers.[1]

With respect to relapse prevention for those with dual disorders, the same CSAT report suggests that:

> Relapse should be defined as engagement in any unsafe behavior such as alcohol and other drug (AOD) use, self-harm, and noncompliance with medications. Relapse prevention should focus on preventing AOD use and recurrence of psychiatric symptoms.[2]

6.1.6 Women, Violence, and Continuing Care

As has been noted elsewhere in this document, a high proportion of women in treatment have been adult or childhood victims of emotional, physical, or sexual abuse (including incest) and/or have been exposed to violence in their communities, or suffered the loss of a family member or friend as a result of a violent crime. Many may be vulnerable to continued abuse in their current or former relationships and to continued exposure to violence in their communities. Therefore, it is critical that the program staff help to ensure insofar as possible that clients have adequately addressed their issues related to past exposure to violence. Also, they need to have access to services to continue to address problems associated with injuries resulting from abuse.

The staff should be aware that relapse can be related to difficulties in coping with unresolved issues related to a history of abuse.

In the latter regard, arrangements should be made for clients to be referred to individual or group counseling as necessary and to support groups (e.g., those associated with rape crisis centers or women's therapy groups) in their community. They should also be provided with information that can be used in the event that they are exposed to abuse in the future (e.g., contact information for a local shelter for battered women). For women who may be in relationships in which they are vulnerable to abuse, the staff should, as part of a discharge plan, help them to develop a "safe plan" which includes strategies for immediately resolving abuse issues in the future. For women who are self-mutilating (which can be an outcome of abuse), this safe plan should include strategies for self-care.[3]

The staff should also be aware that relapse can be related to difficulties in coping with unresolved issues related to a history of abuse, or to concerns related to current vulnerability to either personal violence resulting from a relationship or exposure to violence in their community. Therefore, for women with a history of abuse or exposure to violence (and in particular for those vulnerable to continued abuse and/or exposure to

violence), understanding the relationship between emotional and psychological reactions to such abuse is important.

Perhaps the most sensitive issue in continuing care of the woman who is involved in a relationship where abuse is likely to continue is the family reunification approach taken by the treatment program. While the safety of the woman is paramount, it is also important for the program to empower the woman to deal with the potential for exposure to abuse. In addition to the accurate assessment of women early in treatment, and addressing abuse history during treatment (see Chapter 5), the program should pay particular attention to providing these clients with information that can be used should abuse recur. Covington has suggested that such information include use of restraining orders, in addition to hotlines and contacts for shelters (see above).[4]

6.2 Community and Interagency Collaboration: Referrals and Resources

Interagency collaboration can be a powerful tool to ensure that recovering women receive necessary services during the transitional or continuing care phase of treatment and when they return to the community. It is important to form strong bonds with other agencies and community groups that have the expertise and capacity to provide services to these recovering women, such as departments of corrections and criminal justice (adult and juvenile), child protective services, the Department of Veterans' Affairs, domestic violence agencies, rape crisis centers, employee assistance programs, health maintenance organizations and other health service providers, women's resource centers, family centers and independent living centers as well as other disability advocacy groups. The program staff also needs to interact with community organizations and service agencies to establish a cohesive mechanism that will enable case managers to monitor

a client's progress. An assigned individual within each agency can track the client's progress and provide her with access to services and programs.

During discharge planning, staff must ensure that a woman who is moving into continuing care has a comprehensive list of available resources and services, and they must provide clear directions for accessing these services. The counselor should discuss referrals with clients so they know exactly what services they can expect from providers. Staff members should make certain that if a client is not literate, is not English-speaking, or has other communication problems, she knows how to follow through with referrals. To prevent crises that could contribute to relapse after discharge, program staff should work with other community health providers to establish or expand a crisis/support hotline for women who have left inpatient treatment and are now living in the community or who have completed outpatient care.

Treatment programs empower recovering women by helping them gain access to appropriate supportive resources.

It is critical for a treatment program to establish, to the greatest extent possible, working relationships with groups in the community that provide safe and appropriate recreational resources for women reentering the community after residential or outpatient treatment. Treatment programs empower recovering women by helping them gain access to appropriate supportive resources. Identifying and involving women in activity centers (recreation, group meals, education programs, social events) facilitates the process of meeting and socializing with other women. Introducing recovering women to community-based volunteer programs in which they can participate not only benefits the community, but will improve clients' social skills and self-esteem and widen their circles of associations and networks of support. Every treatment program must evaluate its existing referral mechanisms. For example, because recovering women should be referred to continuing care programs that are culturally and ethnically appropriate, program staff should make sure that service providers have a successful record of working with women of various population groups.

Staff should not hesitate to identify and intercede in referral relationships that are clearly discriminatory or counterproductive to the client's recovery. Individuals in other organizations may misinterpret actions and behavior of people from different ethnic and racial minority groups and react in ways that discourage further contact. Also, to determine whether women are receiving needed services in a timely manner, programs can invite clients to join a focus group that will provide information to help evaluate the referral system.

Collecting accurate and up to date data on and conducting an analysis of community resources for serving women in recovery is also critical. Because such endeavors often require resources that the program itself may not have, these may be carried out in conjunction with other human service agencies. Working collaboratively, and forming consortia among the local providers to address accessing resources can be helpful. Identifying strengths, weaknesses, service gaps, duplications and capacity, and reporting these findings to policy makers, social service organizations, alcohol and drug associations, community leaders, and the media will not only improve the visibility of the program but could facilitate fundraising.

6.3 Support Groups

Recovery issues pertaining to self-esteem, sexuality, sexual abuse and violence, cultural roles/identity, communication skills, assertiveness, stress management, family and other relationships, and health, are ongoing for women and should be addressed during treatment as well as during continuing care. Women in recovery can address these issues by establishing connections with recovering women in self-help groups as early as possible during treatment and after discharge. A foundation or a new "family" of other recovering women can be created by holding ongoing support meetings and facilitating daily phone contacts. Peer retreats or weekend experiences that reunite treatment program participants can help

women maintain treatment gains and provide positive experiences for their new lifestyles.

Programs can also develop networks of recovering people who will volunteer to serve as temporary sponsors and act as "big sisters" to women reentering the community after treatment. It would be helpful to have the clients meet these volunteers before they leave the treatment program. Women's organizations such as sororities, the Older Women's League, and support groups for abused women are good resources for such "buddy" activities. The program could also advocate for new or increased women-only 12-Step or comparable support groups such as Adult Children of Alcoholics, Codependency Anonymous, Women for Sobriety, as well as groups specifically designed for populations such as lesbian, adolescent, and older women. The program could offer the use of space in its facility when possible. Hosting social events for clients, alumnae, and their sponsors allows women to meet and socialize with other recovering women.

Another way to help a woman in this phase of recovery is to enlist the involvement of supportive persons within the cultural and geographic community as early as possible in the treatment process. Telephone chains among program graduates and others help ensure that women receive regular inquiries about their well-being. Some programs have established a 24-hour hotline for recovering women to help them with relapse problems. Some hotlines have a telecommunications device (TDD) to ensure access for women who are deaf.

6.4 Follow-up Strategies and Procedures

Follow-up of clients' status after treatment allows the program to respond to changes in the clients' physical and mental health and socioeconomic status during the continuing care phase of recovery. It also provides programs with information about the effectiveness of treatment. Follow-up

conveys to clients that the program staff maintains concern about their welfare. To ensure effective follow-up, ongoing staff training in treatment, follow-up and tracking of women who leave treatment must be provided. To evaluate a program's effectiveness, follow-up data collected at three-month intervals for a year after treatment can be considered fairly reliable for clinical purposes. However, anything less will not be credible or useful in evaluating treatment programs.

Locating clients after they have completed (or terminated) treatment is essential. Follow-up procedures, which should be part of the treatment process, can make it easier to track clients after their treatment is completed. For example, information obtained at initial contact, such as employment status and current address, as well as the names and addresses of the client's landlord, close relatives, and friends, will facilitate locating the client for follow-up. This information needs to be updated regularly.

It is critical to the recovery process that treatment programs maintain contact with the client as long as is necessary. The program should devise general procedures to follow a client's progress either in person or by telephone until the counselor, case manager, and client feel that follow-up services are no longer required. These procedures must also be adapted to the particular needs and living environment of each client. To avoid abrupt graduations from formal treatment, counselors should schedule incrementally decreasing face-to-face contacts interspersed with regular telephone conversations. During these contacts, the counselor should, without fostering unhealthy dependence, encourage the client to talk with a trusted program staff member as frequently as she thinks necessary and make her feel welcome to return for consultations and other services.

It may be unproductive to begin follow-up counseling by directly questioning the client about her current status with respect to use of alcohol or other drugs. Rather, a more useful approach might be to address the

issue indirectly, for example, by asking the client for her opinion about the quality of service she received and if she believes the service was helpful.

Confidentiality must be carefully observed in the follow-up process.

Confidentiality during client follow-up is also an extremely important issue. Confidentiality must be carefully observed in the follow-up process not only to comply with government regulations but to avoid adverse effects on the client's relationships with others who may not be aware of her treatment. For example, if it is necessary to contact a client's employer, substance abuse cannot be mentioned unless the client has given written consent for disclosure of this information. Similarly, the name of a treatment facility should not be mentioned to friends or family members of the client without her written consent. It may be necessary to construct a plausible cover story in some instances.

References

1. Center for Substance Abuse Treatment. (1994). Assessment and Treatment of Patients with Coexisting Mental Illness and Alcohol and Other Drug Abuse. Rockville, MD: U.S. Department of Health and Human Services, Public Health Service, 60.

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3. Covington, S.S. (1994). Violence and Abuse. Bethesda, MD: Policy Research Incorporated, 3.

4. ibid.