and seek to ensure adherence to basic ethical principles which are considered to apply across cultures and which can be used to guide substance abuse treatment. These principles—in particular justice and nonmalevolence—are of increasing interest to those concerned about civil and human rights and liberties. Jillson has described four ethical principles as they apply to health policy in general; their applicability to substance abuse treatment is as follows:[2]

Client autonomy is an important goal for the client and the treatment staff to work toward during the recovery process.

- The principle of autonomy is the capacity to reason and to alter one's decisions and plans based on such reasoning and to act on the basis of one's decision. Client autonomy is an important goal for the client and the treatment staff to work toward during the recovery process. As the client becomes physically and emotionally stronger, her ability to reason and make decisions must be respected and strengthened as it aids in her recovery. It should be noted that this ethical principle may be difficult to apply early in the treatment process. However, when the client's judgement is likely to be impaired by recent and/or extensive use of alcohol and/or other drugs, such impairment does not absolve the treatment program from its obligation to ensure that the woman's autonomy is protected in the treatment process.

- The principle of beneficence is related to goals held by people and social institutions on their behalf. This is seen by some as the most important moral obligation of health and social service programs. When beneficial goals can be agreed upon by program managers, staff members, and clients, they should be pursued. For example, both the program and the woman might agree that an appropriate treatment goal is for the woman to be employed within a certain period of time. However, beneficial goals can be particularly difficult to implement in substance abuse treatment because there is an assumption that there is an agreed-upon definition of what is beneficial, to whom, and under what circumstances. For example, the treatment program may have treatment goals (and related general outcome indicators) that are not appropriate for every

woman in treatment; moreover, the policy-related goals of funding agencies may differ from those of individual treatment programs receiving funding. Finally, the beneficial outcome for a woman's child(ren) may conflict with treatment approaches designed to ensure a beneficial outcome for the woman herself. For example, while it may be preferable for the woman to have time to recover without having her children with her in treatment, it may be preferable for the children to be with their mother throughout the duration of treatment.

- The principle of equity holds that each person must be given her/his due and that equals must be treated equally. While the treatment program cannot be responsible for ensuring justice and equity in all aspects of their clients' lives, it can ensure that all clients receive equal access to its services, that all are treated with equal respect by program staff, and that attempts are made to provide equal access to services outside of the program. This is critical to women in treatment, particularly to disadvantaged women because services have been disproportionately lacking for them and available services may not address their particular needs. The paucity of related health and social services for disadvantaged clients (and for some populations of women in particular) is also an issue related to distributive justice.

- The principle of non-malevolence, or "first, do no harm," holds that social institutions — in this case, treatment programs — should not impose harm or evil upon those affected by their actions. This is an apparently obvious virtue which, in practice, raises difficult societal issues. An example of how this principle applies in substance abuse treatment is the importance of ensuring that research and evaluation (whose intent is, ostensibly, to obtain data and information for use in improving the delivery of treatment services in general) does not in any way violate the integrity of the woman in treatment. Another is the need to ensure that protecting (as well as improving) the basic physical and mental health of the client is a focal point of service deliv-

ery; for pregnant and post-partum women in treatment, difficult trade-offs may be required of treatment staff. For example, the program may need to determine when it is necessary to make arrangements for placement of a newborn or young child in other living arrangements when the mother continues to abuse drugs and is deemed incapable of caring for the child.

7.5 Linkages with Other Agencies

The importance of establishing relationships with other community-based agencies to ensure that clients have access to comprehensive services has been addressed in Chapters 4, 5, and 6. If the treatment program is part of an umbrella agency that provides services not offered at the program site (e.g., health services), these services can be arranged through the umbrella agency. For freestanding substance abuse treatment programs, the arrangements may either be permanent (e.g., the service provider is part of the staff, either full-time or part-time) or arrangements can be made for regular or as needed consultations at the program site or the site of the service provider.

The program should establish and maintain a network of agencies that can meet the broad range of women's needs. To do so, the program staff should compile a list of health and other social service agencies that are resources for client services. This list should include the name of the agency, the service provided, its location, the telephone number, hours of service, the cost of service, information on accessibility to women with disabilities, and the name of the contact person. This list should be updated frequently and should be accessible to all staff members for use in referral to comprehensive services.

There are many opportunities throughout the treatment process for contacts with organizations that do not refer clients. For example, the

program staff could collaborate with a local school/community college, university, or other organization that houses a media center to produce a professional quality audiotape or videotape on women and substance abuse treatment and mental health. Such materials would be useful to the program itself, to other providers in the community and to use in prevention and outreach by a broad range of organizations. Some collaborating agencies provide such production services free of charge, if they are assured proper credit for their efforts. Involving the clients in the process of planning for and producing the tape can be a challenging and rewarding experience for both clients and counselors; it is also likely to enhance the tape's usefulness. Other examples of contacts include exchanging training resources (mentioned previously in this chapter), setting up coalitions to exchange information on changes in health systems delivery and financing and its effect on substance abuse treatment programs, and exchanging written and audiovisual materials.

7.6 Financing Mechanisms

Because women need more and different comprehensive services than are generally provided to men, it is likely that additional costs will be incurred.

Because women need more and different comprehensive services than are generally provided to men (e.g., child care, perinatal care, injuries resulting from sexual abuse and violence), it is likely that additional costs will be incurred to provide and arrange for the services for women that are described and recommended in this manual. Creative strategies must be employed to secure public and private money to fund the essential services that recovering women require. Examples of funding sources for treatment programs include the following:

- direct grants from federal agencies (e.g., CSAT, NIDA, NIAAA, Office of Minority Health);
- funding from the state alcohol and drug abuse authority, including the Substance Abuse and Mental Health Services Administration (SAMHSA) block grant funds, five percent of which are set aside for women's programs;

- grants from local and national private foundations that support substance abuse treatment programs specifically or health services for women and/or children generally; and

- state Medicaid agencies.

Ongoing and one-time donations from women-owned businesses, businesses targeting female consumers, and women's organizations can help to support nonprofit women's alcohol and other drug treatment programs. By involving these organizations either through defined collaborative arrangements or by having representatives serve on the program's board of directors, programs may be establishing relationships for potential financial support. Treatment programs can also sponsor community-wide symposia of issues directly and indirectly related to alcohol and other drug abuse and invite representatives of potential funding sources to speak or participate. In addition, programs can design and implement income generating projects to help ensure that the programs are economically self-sufficient to the degree possible.

To help gain their support for treatment of women, (including their economic support) community leaders need to be educated about treatment of women. Program staff, either independently or in coalition with other organizations, can encourage third party payer organizations to have insurance and managed care coverage reimbursements more in line with realistic costs for substance abuse treatment and intervention. If these efforts do not elicit an appropriate response from insurance companies, managed care providers, HMOs, and public medical assistance programs, it may be necessary and desirable to join with other agencies and community groups providing services for substance-abusing women to advocate for local and state legislative and administrative changes. Pennsylvania, for example, has successfully begun to mandate Medical Assistance reimbursement for long-term, halfway house services and to require insurance

companies to provide at least minimal coverage for treatment of alcohol and other drug problems.

Each treatment program should have a development plan that includes identification of resource needs, potential sources of funding, and strategies to ensure financial sustainability. CSAT has issued a guide entitled "Funding Resource Guide for Substance Abuse Programs" that programs can use to assist them in preparing and implementing such a development plan.[3]

References

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