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# Treatment Programs for Drug-Abusing Women

Karol L. Kumpfer

## Abstract

What is known about drug treatment effectiveness is based primarily on studies involving men. Little is known about treatment effectiveness for women, particularly pregnant women. Available research and clinical evidence demonstrate that some types of drug treatment can have positive effects in such areas as drug use, employability, and criminal behavior. Drug treatment modalities include residential programs (both long-term therapy and short-term drug dependency hospitals and treatment centers) and outpatient programs, including intensive day programs. Barriers that prevent women from getting the treatment they need include lack of programs that admit women, and pregnant women in particular; lack of programs tailored to women's needs; and the fear and isolation experienced by most drug-abusing, pregnant women. New federal and state initiatives are targeting this underserved population. In addition, federally-funded, large-scale demonstration and evaluation projects employing diverse approaches are currently underway. Many experts believe that the most effective treatment approach is a comprehensive model program that includes specially trained staff; provision of physical, social, medical, educational, child care, and vocational services; and involvement of the family in therapy. The conclusion is that more programs tailored to women are needed. More research is also needed regarding treatment effectiveness, as well as the etiology of alcohol and drug abuse. To this end, the government must play a major role in funding longitudinal and multisite studies.

**I**ncreased attention to the problem of drug-exposed infants leads naturally to an inquiry about drug treatment effectiveness. Unfortunately, relatively little is known from scientific research about the effectiveness of different modalities of treatment for drug abuse. Furthermore, what is known has been developed primarily from studies involving men, with little attention to women, let alone pregnant women. On the other hand, there is some research evidence, and more clinical evidence, that for some people some types of drug treatment can accomplish to varying degrees outcomes such as decreased criminal behavior, increased employability, and decreased drug use or even abstinence. We also know that despite the uncertainty about treatment effectiveness, the demand for treatment is much greater than the supply.

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This article briefly discusses treatment modalities and effectiveness research; barriers for women in obtaining treatment; federally funded research and demonstration projects regarding treatment for pregnant women and women with children; and some state initiatives and model programs recently initiated to begin meeting the treatment demand for this population.

## Treatment Modalities and Effectiveness

Drug treatment services are offered through a variety of modalities, relying either on a residential or outpatient approach. Within these categories there is substantial variation. In residential programs, there are both long-term therapeutic communities and short-term drug dependency hospitals or treatment centers. Within outpatient programs there are those that involve frequent and intensive programs and those that consist of one or two hourly sessions per week.

### Treatment Modalities

The following is a general description of four major treatment modalities:

- **Residential, Therapeutic Communities.** This type of program targets the most heavily impaired, polydrug users. It removes drug users from their environment and immerses them in a structured, intensive program. These programs often revolve around a set of norms and a system of rewards and punishment. The client is expected to comply with this system and often to participate in the housework and other tasks of communal living.<sup>1</sup> These programs typically do not allow children of clients to live in the residence and thus require some other custody arrangement for any children. The length of stay in such a program can vary but most often is for several months or even a year.

- **Residential, Drug Treatment Centers.** This is the most widely used treatment modality, probably because it is what is typically covered by private insurance policies. Like therapeutic communities, these centers also target highly impaired drug and/or alcohol users.<sup>2</sup> They also provide a residential, highly structured program,

but for a shorter period of 14-28 days. They typically offer detoxification and a comprehensive therapeutic package. Like therapeutic communities, these programs usually do not allow children to live at the center. Unlike therapeutic centers, these drug treatment centers do not typically require the client to participate in the chores of communal living.

- **Outpatient—Intensive.** Some residential programs have developed daily outpatient programs for those clients who require intensive therapy but cannot live at the center. This type of program can be an attractive alternative for clients with children, but the programs must be located near where the client lives, or be easily accessible by public transportation.

- **Outpatient.** This category has the most diversity of programs. Typically, outpatient programs, which target less impaired drug users, are less expensive than residential and intensive outpatient services. These programs are offered by a vast array of providers, including drop-in centers, community mental health programs, self-help groups, clergy, and private counselors. Some also provide ancillary resource and referral for such services as vocational training, remedial education, and entitlement assistance. Few, however, provide ancillary services geared toward children, such as child care, parent education, and prenatal and perinatal health care.

Within the residential categories, there are also prison programs, mental hospital programs, and detoxification-only programs. All of these residential and outpatient programs rely on different therapeutic approaches, with one of the most common being the Twelve Step program used in Alcoholics Anonymous (AA), in which patients follow the 12 steps of AA to grow mentally, emotionally, and

spiritually.<sup>3</sup> This approach stresses individual responsibility and recovery, rather than family therapy.

According to the 1987 *National Drug and Alcoholism Treatment Utilization Survey*, the vast majority of programs now treat both drug and alcohol problems. In 1987 the drug treatment system consisted of 2750 outpatient (nonmethadone) treatment programs; 1000 hospital programs; 1000 residential, nonhospital programs; 330 methadone maintenance outpatient programs; and 72 correctional facilities with programs. Eighty-six percent of all people in treatment (225,000 of 263,000 in treatment as of October 1987) were in outpatient programs.<sup>4</sup>

### Treatment Effectiveness

The Anti-Drug Abuse Act of 1986 mandated an independent study of substance abuse treatment coverage. This task fell to the Institute of Medicine (IOM), which, under contract with the National Institute on Drug Abuse (NIDA), worked by committee with the National Academy of Sciences to study this issue through review of the scientific literature and through specially commissioned papers, conferences, and consultation with other experts. This discussion of treatment effectiveness highlights some of the findings from this recent, comprehensive compilation of current research knowledge.<sup>5</sup>

In the preface to its findings, the IOM Committee acknowledged the limitation "imposed by the scarcity of research data since the onset of the crack-cocaine era concerning treatment for drug dependence in women who are pregnant or mothers of young children." Nevertheless, the IOM's review of drug treatment literature can be instructive in understanding treatment issues generally.

The IOM Committee discovered that the most extensive and scientifically best-developed evidence concerns methadone maintenance, and the least amount of research exists about the short-term, inpatient drug treatment centers. Ironically, it is this latter category of program that absorbed the most revenues in 1987, an estimated \$500 million. Despite this high level of investment, the IOM found that "there are no relevant experimental or quasi-experimental studies" of this treatment modality, and "the extent of reasonably certain knowledge" is limited to knowing that clients treated for alcohol problems

have better outcomes than those treated for drug problems.

More research exists about therapeutic communities (TCs). After reviewing the literature of two federally-funded longitudinal studies and several studies focusing on single, therapeutic, residential, community programs, the IOM Committee found the following evidence from the studies to be persuasive: attrition from these programs is high (although not as high as for outpatient programs); TC clients demonstrate better behavior during treatment and after discharge than before admission; and TC clients who stay in TCs for at least a third or half of the planned course of treatment (at least 2-12 months and probably a minimum of 3 months for long-term users) show improvement over drug users who did not enter treatment or who dropped out after shorter periods of time. These improvements over nontreatment vary with the amount of time spent in treatment and may include one- to two-thirds reductions in the rates of primary drug consumption and other criminal activity, and 50% increases in the rates of employment or schooling.

As discussed above, the highest enrollment is in outpatient treatment. After reviewing studies of nonmethadone, outpatient treatment programs, the IOM Committee reached the conclusion that outpatient clients demonstrate better behavior during and following treatment than before treatment, and clients who remain in treatment longer have better outcomes at follow-up than shorter-term clients. At least one major study reviewed by the Committee suggests that the critical retention threshold is 6 months, but found that only 17% of the 1600 outpatient clients tracked stayed in the outpatient programs for that period of time. Another study showed results similar to those for residential, therapeutic communities: if the client stayed in the program for less than 90 days, there was no significant outcome improvement; after 90 days, outcome scores were strongly and significantly correlated with total length of stay.

Most of these studies look at treatment outcomes in terms of drug use, criminality, and employability. They do not consider proper childrearing in their outcome analysis. The question arises as to whether the results they have found are applicable to women, let alone pregnant women and children.

IOM acknowledged this lack of research about women in treatment. "The majority of individuals in treatment are adult males who are 20-40 years old, and their responses dominate treatment research statistics."<sup>6</sup> A number of the major studies reviewed by IOM, however, included women participants, even though no separate analysis was done for them. In recommending that high priority be given to drug treatment for pregnant women, the IOM committee concluded that "[t]here is no basis to believe that treatment of these women would be appreciably more or less effective than for other adult clients."<sup>7</sup>

## Barriers to Treatment for Women with Children

Only a small percentage of addicted women ever enter a substance-abuse treatment program. The IOM Committee estimates that there are approximately 105,000 pregnant women each year who need drug treatment. Only 30,000 of these women receive any form of treatment, and very few of these are in programs with a primary focus on special services for pregnant women.<sup>7</sup>

This unmet demand extends throughout the country. In 1985 Kumpfer found in Utah that only about 7.3% of all women abusing drugs and alcohol were receiving treatment.<sup>8</sup> Women in urban areas were much more likely to receive treatment (17.8%) compared to women in rural, isolated areas (2.2%). Only 13.5% of the clients in treatment facilities were women (down from 28% in 1978).<sup>8</sup> Furst and associates reported in 1981 for California that there were four times more men than women in publicly-funded treatment, and two and a half times more men in all treatment programs, public or private.<sup>9</sup>

Three primary obstacles to treatment may explain why such a low percentage of women receive treatment:

1. The lack of alcohol and drug treatment facilities and specialized programs for women;
2. The lack of quality female-model (vs. male-model) treatment approaches that are sensitive to women's needs; and
3. The fears and sense of isolation experienced by most drug-abusing, pregnant women.

## Lack of Women's Treatment Facilities and Programs

Two thirds of major hospitals in 15 cities included in a 1989 survey commissioned by the House Select Committee on Children, Youth, and Families reported they had no place to refer drug-dependent, pregnant women for treatment.<sup>10</sup> The major factors contributing to this deficit are inadequate public funding for drug treatment for women and exclusion of pregnant women from most existing treatment programs.

Public funding for women's drug treatment has been historically inadequate. Most publicly-funded alcohol or drug treatment programs were designed for indigent, single men. In 1975 only about 21% of the estimated number of female drug addicts received treatment in federally-funded programs.<sup>11</sup> In 1976 the need for special treatment services for women was recognized, and new federal legislation, P.L. 94-371, was enacted to increase such services. In addition, a network of women's task forces was created by the National Council on Alcoholism's Special Office on Women. However, by 1978 only 3% of programs funded by the National Institute on Alcoholism and Alcohol Abuse (NIAAA) (17 of 578 programs)<sup>12</sup> were available to female alcoholics, and 20% of programs funded by NIDA were available to female heroin addicts.<sup>13</sup> In a 1980 national survey, Beschner and Thompson identified only 25 "specialized women's" programs nationwide serving 547 women.<sup>14</sup> Only half of these provided psychological and family counseling, and one third provided skills assessment and educational counseling.

In 1981 the slow progress came to a halt when all treatment program funding by NIDA and NIAAA was reduced by 40% and shifted to the Alcohol, Drug Abuse, and Mental Health Administration (ADAMHA) categorical block grants administered by the states. At the same time, the federal data systems were dismantled, and few states continued tracking the number of women in treatment. Faced with this reduced funding, many specialized women's treatment services and programs were absorbed into the traditional treatment system or closed.

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In 1984 the National Council on Alcoholism and supporters in Congress again recognized the problem of lack of treatment for women and enacted P.L. 98-509, known as the Five Percent Women's Set Aside, which required that 5% of the federal block grant to each state be set aside to provide treatment services for women. In 1988 this requirement was increased to

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*Treatment programs cite numerous legal and medical concerns as justification for excluding pregnant women . . .*

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10%. Although this legislation highlighted the sorry state of public treatment services for addicted women, it did little to increase services for women; no new funding was allo-

cated. Most states simply met the set aside requirements by including existing women's slots or services in the category, even those that primarily served men but included some family treatment.

Lack of treatment for women is also attributable to exclusion by private treatment programs of women who have no health care insurance or who are on Medicaid. In fact, residential treatment programs cannot bill Medicaid, because they are considered "institutions for mental disease." In 1990 the Coalition on Alcoholic and Drug-Dependent Women and Their Children of the National Council on Alcoholism and Drug Dependence sponsored S. 3002, the Medicaid Drug Treatment for Families Care Act of 1990. This legislation would extend Medicaid coverage to support long-term, residential, alcohol and drug treatment for pregnant women and women with young children for up to 12 months by exempting these residential programs from the "institution for mental disease" exclusion. The legislation was not passed and will be reintroduced in 1991. Some states, however, are rewriting their Medicaid regulations to allow state Medicaid dollars to be used for women's residential treatment.

#### **Exclusion of Pregnant Women and Women with Children**

Even those treatment programs that accept women often refuse to admit women who are pregnant. No accurate data currently exists on the number of treatment programs that will serve pregnant women, but as discussed above, the IOM estimates that only 30,000 of 105,000 pregnant women who need treatment get it. Other studies document the need in particular

areas. Miller reports that in Boston there are only 30 residential treatment slots for pregnant women addicted to cocaine, yet one hospital in Boston alone reports over 300 mothers delivering there use cocaine.<sup>10</sup> Portis recently reported at the NIDA National Conference on Drug Abuse Research and Practice that in the entire state of Massachusetts there are only 51 treatment beds for pregnant, drug-abusing women, yet there are several thousand such women. The waiting lists are long to get into such programs, particularly for minority women; 82% of the pregnant women in treatment are White women.<sup>15</sup> In Chavkin's New York study, 54% of the 78 drug treatment programs surveyed refused to treat pregnant women. Even more (67%) refused to treat pregnant women on Medicaid, and only 13% would accept crack-addicted, pregnant women on Medicaid. Only 10% who accepted Medicaid women provided detoxification. Fewer than half of these programs provided or arranged for prenatal care.<sup>16</sup>

Finally, few drug treatment services can accommodate women with children, either through outpatient treatment with child care or in a residential program for mothers with their children. In their 1980 national study of drug treatment facilities, Beschner and Thompson found that few programs provided services for the children of drug-abusing women.<sup>14</sup> Only two programs in a New York state study provided child care.<sup>16</sup> Only 4% (16) of the 399 publicly-funded drug treatment programs in California treat women with their children.<sup>17</sup> The 1986 Association of Junior Leagues International, Inc. survey of 3500 providers in 34 states found that only 8% of alcohol treatment providers offered child care and only 29% had programs for children. This study identified child care as the number one unmet need.<sup>18</sup> Magjaryi reports, "The lack of on-site child care facilities is a formidable barrier to women seeking treatment, especially for single mothers with small children. Although this is an obvious and commonsense service for agencies to provide, on-site child care in both outpatient and residential settings is currently rare."<sup>17</sup>

Treatment programs cite numerous legal and medical concerns as justification for excluding pregnant women: concerns about detoxification during pregnancy, lack of prenatal care, lack of facilities for the infant when born if the woman is in a long-term residential program, and their

inability to become a licensed child care facility or nursery. The American Civil Liberties Union Foundation describes “widespread discrimination against pregnant women in alcohol and drug treatment programs,” and so far, “no states have passed laws that prohibit such discrimination.”<sup>19</sup>

Formidable barriers discourage drug and alcohol treatment programs from meeting the housing, child care, and other social needs of drug-abusing mothers. Typically, such programs do not have the space or licensing for children or for service delivery to children and their mothers. Even when a facility can accommodate a mother and her newborn, it often will not allow older siblings into the program. Of those few that will accept older children, most have an age limit of 5 years. Thus, women with children, particularly older children, must often choose between continuing custody and care for their children and drug treatment.

#### **Lack of Treatment Programs Sensitive to Women’s Needs**

Most of the barriers to treatment discussed above relate to availability. Additional barriers to treatment include accessibility, quality, safety, and attractiveness to women. Because the drug and alcohol dependency treatment system was largely developed at a time when men were being targeted for treatment, “little attention has been paid to specific women’s treatment issues, including the different emotional, social, and economic realities of women’s lives.”<sup>20</sup> The realities of addicted women are that they are often (1) poor, unemployed, and lacking in employable job skills; (2) single, divorced, or separated, and often isolated from social support systems; and (3) mothers of children who need their care and attention.<sup>21</sup> According to a recent, unpublished study by Chavkin of 115 drug-abusing women, both in and out of treatment, most of these women had been technically homeless and sexually or physically abused sometime in the last 2 years.<sup>22</sup> For treatment programs to be attractive and responsive to these women, they must recognize their needs and the support required to meet those needs. Burkett suggests providing prenatal care as the “hook” for getting women to participate in the treatment program.<sup>23</sup>

The different needs of women may also recommend a different type of therapy. As the IOM Committee noted, drug-abusing women on average have poorer self-es-

teem than men and suffer greater anxiety, depression, and detachment. As a result, too much reliance on confrontational therapy techniques may worsen such problems rather than help reduce them.<sup>24</sup> Drug-dependent women are also more likely to be adult children of an alcoholic (ACOAs) or of a drug abuser and to be in a relationship with another drug-dependent person.<sup>25</sup>

Finally, improving parenting is an important need of many drug-abusing mothers. It has been suggested that classic therapeutic methodologies have to be modified to meet the needs of this special population, and that parenting issues should be a primary focus.<sup>26</sup> Some research does exist concerning the effectiveness of programs for this population. Kumpfer and DeMarsh reported that a comprehensive family skills training program in Salt Lake City, Utah, the Strengthening Families Program, was successful in improving parenting skills of drug-abusing parents and in decreasing behavioral and emotional problems in 6- to 12-year-old children of drug abusers.<sup>27</sup> This NIDA-funded program included 14 weeks of parent training and extensive work with the children alone and the family as a whole. This program has been replicated successfully with Black, addicted mothers in Alabama and is being implemented with federal funding from the Office for Substance Abuse Prevention (OSAP) in Detroit, Utah, and Hawaii, where culturally-sensitive versions are being developed with local and national consultants.

#### **Fear and Isolation in Women**

Women’s treatment literature has long identified the stigma of treatment and the fear of being labeled a “bad or fallen” woman as barriers to women seeking treatment. A woman who drinks too much or uses drugs is looked down upon more than a man who engages in the same behavior. The “hand that rocks the cradle is not supposed to be a shaky one.”<sup>28</sup> According to Finkelstein, an alcohol- or drug-abusing, pregnant woman has “two strikes against her in our society: she is a woman, often considered a second-class citizen, and she is seen as sexually promiscuous, weak-willed, shamefully negligent of her children, and irresponsible in her ‘decisions’ to bear more children.”<sup>20</sup> Many contend that as stigma, rejection, and blame increase, drug-abusing women’s feelings of guilt and shame increase. This leads to lowered self-esteem, increased depression,

immobilization, and isolation. As societal stigma increases, willingness to enter treatment decreases.

In addition, fear of criminal prosecution and fear of loss of child custody was reported as a major barrier to participation by over three fourths of pregnant women in a recent study by Burkett.<sup>23</sup> Armanda and Aguiar of the Mom's Project at Boston University found that only one fourth of the 466 pregnant, drug-abusing women interviewed in their research had ever been in treatment, because most of the women feared recrimination. This project found that a "drop-in center" reduced fear of involvement.<sup>29</sup>

## New Initiatives

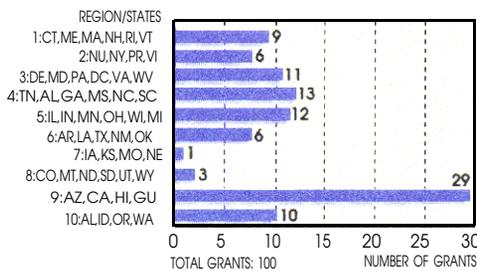
### Federal Initiatives

#### NIDA Research Projects

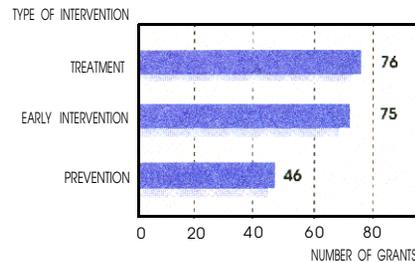
With the Anti-Drug movement of the late 1980s, federal funding for treatment and research is once again increasing. Some of this will be targeted for pregnant women. To date, NIDA has funded 20 research projects and NIAAA has funded 10 to study the effectiveness of alcohol and drug treatment programs for pregnant women. Many of the programs being studied provide not only treatment, but also pediatric and prenatal care, vocational and educational training for the mother, and hous-

### PPWI Grants for 1989-1990

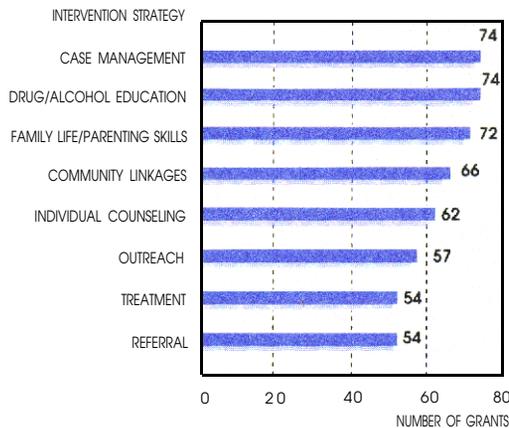
#### 1. Distribution by DHHS Region



#### 3. Type of Intervention

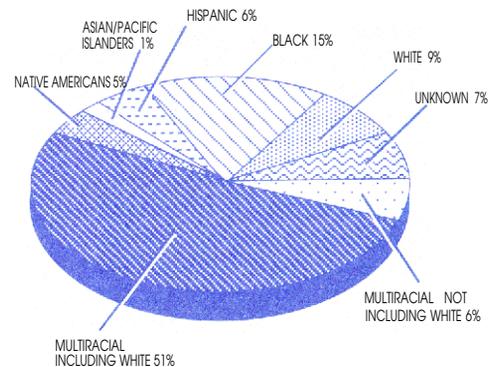


#### 2. Most Widely Used\* Intervention Strategies



\*Must have been proposed by at least half of the grants.

#### 4. Race/Ethnicity of Target Population



Under the Anti-Drug Abuse Act of 1988, comprehensive demonstration projects were established for pregnant and postpartum women and their infants, known as PPWI projects. Figures 1-4 summarize data on 100 PPWI grants awarded in 1989-1990. Figure 1 illustrates the geographical distribution by Department of Health and Human Services regions; figure 2, the 8 most widely used intervention strategies; figure 3, the different types of intervention used by PPWI grantees; and figure 4, the target population in terms of race and ethnicity.

Source: Marilyn Rice, chief of the Perinatal Addiction Prevention Branch, Office for Substance Abuse Prevention, Rockville, Maryland.

ing. These research projects are scheduled to continue over the next 5 years.

#### PPWI Projects

The Anti-Drug Abuse Act of 1988, P.L. 100-690, Sections 509F and 509G, provided for the establishment of comprehensive demonstration projects for pregnant and postpartum women and their infants (PPWI), to be administered through OSAP. The Office of Maternal and Child Health is collaborating with OSAP in this initiative through a part-time staff member. OSAP began funding these programs in September 1989; 100 demonstration and evaluation PPWI projects were funded during 1989-1990. The goal of these projects is to increase availability and accessibility of both treatment and medical care for pregnant women. Although they include an evaluation requirement, these are typically not scientifically rigorous evaluations. As part of the OSAP National Evaluation plan, there is some work being done by this author and others to coordinate the information gathered among the projects by developing common evaluation measures. The outcome data to be collected is of two types: required and voluntary. Required data includes demographic data, number of women participating, and which services they used. Data collected on a voluntary basis includes the specific health status of participating women, information on their psychological, mental, and physical health, their progress during treatment, and data on outcomes at the conclusion of treatment. The programs are just now being implemented and will probably not have any outcome data for 2-5 years, depending on the project.

A recent list of the 100 PPWI projects<sup>30</sup> awarded in 1989-1990 shows considerable diversity, as summarized in figures 1-4.

#### State Demonstration Programs

State treatment initiatives for women were recently described in a survey of state prevention coordinators participating in the National Association of State Alcohol and Drug Abuse Directors (NASADAD).<sup>31</sup>

Sixty percent of the responding states report they are developing new treatment services for women and children; 28% are developing new prevention services for women's drug use; 24% mentioned developing professional training; and 32% are developing coordinating task forces with other state and local agencies to assure the multiple needs of pregnant, drug-abusing

women are being met. In addition to the Commonwealth of Puerto Rico, the 15 states reporting development of new women's treatment services include Connecticut, Florida, Georgia, Illinois, Kentucky, Louisiana, Massachusetts, Minnesota, Missouri, New Mexico, New York, Pennsylvania, South Carolina, and Wyoming. All but three of these are planning additional residential treatment centers for women, many to include children. Because half of the 50 states did not respond to the survey, it is not known if this sample is representative of all the states' initiatives.

#### Options for Recovery

Although not mentioned in the NASADAD report, probably the largest state initiative directed at pregnant, drug-abusing women is Options for Recovery, being developed in California, where a 25-cent per pack tax increase on cigarettes has been earmarked for model demonstration projects for drug-abusing women with children. Four counties were selected for the model pilot projects: Los Angeles, San Diego, Alameda, and Sacramento. In Los Angeles County, Options for Recovery provides an extra \$3.3 million for underserved, pregnant addicts in South Central Los Angeles and the Harbor region. This money is funding new and expanded residential and outpatient drug treatment programs, such as the Southeast Council's mother and child residential programs: Baby Step Inn (12 beds), in Long Beach, and Foley House (24 beds), in Whittier. Both will provide additional treatment referral sources for an already existing PPWI program at the Harbor-UCLA Medical Center.

In San Diego the 3-year pilot project, with an annual funding of approximately \$1.5 million, will reach over 200 women and their families each year. The services include intensive drug and alcohol recovery services, case management for 2 years, and foster care recruitment and training of specialized foster care homes for drug-exposed infants. In addition, day treatment options are being developed in the San Diego pilot through the Episcopal Community Services in Chula Vista and EB Crisis and Counseling Services in San Marcos.

#### Some Model Programs

Many experts believe that the most effective treatment model for pregnant, drug-dependent women is the comprehensive model program.<sup>21,32</sup> The following services should be included in a model program: (1) staff that is trained and sensitive

to pregnant addicts' issues, (2) provision of adequate physical, interpersonal, and social supports, (3) family involvement in therapy and child care, (4) obstetric, pediatric, and medical care for women and infants, and (5) educational and vocational assistance.<sup>33</sup> There are a number of programs in the country that are attempting this comprehensive approach. Unfortunately, most of these do not have sufficient funding for rigorous evaluation of their effectiveness.

In 1989 the Center for the Vulnerable Child at Children's Hospital in Oakland, California, conducted a national search for model programs providing comprehensive services to drug-dependent women and their children.<sup>34</sup> Ten model programs were identified through the literature, media, and other providers and specialists in the field. Generally these programs are funded by a great variety of time-limited private and public grants. The results of the survey have not been published, but according to its authors there was little data available on effectiveness of these programs. Most of the programs provide primarily outpatient services in an attempt to meet the multiple needs of the mothers and infants; most do not provide residential or inpatient treatment.

One of the most comprehensive programs nationally is Operation PAR (Parental Awareness and Responsibility) in St. Petersburg, Florida. Operation PAR is an alcohol and drug treatment and parent education agency that has developed a comprehensive service capacity, providing "one-stop shopping" for pregnant, drug-abusing women.<sup>32,35</sup> It is probably the most comprehensive program for addicted women and their children in the country. Operation PAR provides maternal health services, counseling, and almost all major social support services. It does not provide primary medical care and well baby care for the infants but is planning for improved health care access and protective services. They offer a continuum of treatment services for pregnant addicts located in the high drug-using area, including detoxification, residential treatment, a 5-day-per-week day treatment program, outpatient counseling and case management services, licensed early-intervention child care centers, and capacity to place additional children in individual family day care homes with trained child care mothers from the community. Transporta-

tion is provided for day treatment and outpatient services as well as to bus children living in the separate drug-free homes to schools. Evaluation through a NIDA-funded research project is just beginning as the program is currently being developed.

These model programs offer the hope that many more pregnant women will receive comprehensive services, including drug treatment. Unfortunately, while many of those involved with the programs believe that they are effective in helping many women to control or eliminate their drug and alcohol use and provide proper care for their children, their effectiveness has not been adequately evaluated. Another model NIDA-funded project for pregnant, drug-abusing women is run by Amity, Inc. in Tucson, Arizona. This program has found increased positive treatment outcomes from a 5-year pilot study of 149 women who are court-enrolled and have children residing with them in residential treatment. They found significantly longer retention in treatment and significant improvements in post-treatment success after participation in the female-based, therapeutic model.<sup>36</sup>

## Conclusions

There are a number of unanswered questions concerning treatment for drug-abusing women and their children: (1) Why do women become addicts? (2) What treatments are effective in producing which outcomes? (3) Can treatment be effective if mandated or coerced? and (4) When is the best time to offer treatment? We do not have definitive answers to these questions now, although there is considerable clinical experience to draw from. More research is needed, and the federal government must once again play a major role in funding longitudinal and multisite studies.

In addition to treatment effectiveness research, we need more etiological research. Multiple factors, including genetic (family history), biological (Briquet's Syndrome, PMS, depression), psychological (low self-esteem, thrill seeking, dual diagnoses, identification with a deviant lifestyle), and sociological factors (isolation, losses, abuse, drug-using friends) probably combine to cause alcohol and drug abuse.<sup>37,38</sup> Understanding the roots of drug abuse better will help in the design of more effective treatment systems.

In the meantime, programs should be designed and funded to provide a wide range of treatment options. One of these options should include comprehensive, family support center programs that provide to pregnant women and new mothers, on an outpatient basis, not only drug treatment therapy, but also child care, health education, and food and housing assis-

tance. Such a program will likely benefit not only the women, but also their children.

Ultimately, treatment capacity must be developed so that any drug-abusing woman who is pregnant or has young children and seeks treatment can receive treatment. Eliminating waiting lists for this population should be a high priority.

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2. See 1., pp. 167-68.
3. Al-Anon Family Group, New York. *Al-Anon's twelve steps & twelve traditions*. New York: Al-Anon Family Group Headquarters, Inc., 1990.
4. See 1., p. 209.
5. See 1., chaps. 3, 5.
6. See 1., p. 198. There is also lack of research about treatment of women for alcoholism. Emrick reviewed 271 treatment outcome studies over a 20-year period, finding that only 110 included women and only 4 focused on women alone. Emrick, C.D. A review of psychologically-oriented treatment of alcoholism: I. The use of interrelationships of outcome criteria and drinking behavior following treatment. *Quarterly Journal of Studies on Alcohol* (1974) 36:523-549. In a 1984 review of alcohol treatment outcomes, Vanicelli found that only 116 of 259 studies included women, and only 30 conducted a separate analysis of women's data. Vanicelli, M. Treatment outcomes of alcoholic women: The state of the art in relation to sex bias and expectancy effects. In *Alcohol problems in women*. S. C. Wilsnack and L.J. Beckman, eds. New York: Guilford Press, 1984, 369-412.
7. See 1., p. 234.
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