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WOMEN AND ADDICTION: TREATMENT ISSUES AND INNOVATIVE PROGRAM MODELS

This article explores the extent to, and ways in which, gender and related factors affect substance abuse treatment for women involved in the criminal system. To illustrate these issues, we draw upon the example of the Crossroads program, operated by the Center for Community Alternatives in New York, NY.

The Need for Gender Specific Treatment

There is considerable evidence of the link between maternal substance abuse and child abuse and neglect. In 1994, 77 percent of the 50,000 reports of child abuse and neglect filed in New York City involved substance abuse and 36,000 of the 47,000 (77%) New York City children in foster care had biological parents who were substance abusers (CASA, 1996). The chemical dependency of women has had an impact on the criminal court as well. Women have been the fastest growing population in the criminal justice system. In 1986, there were 410,300 women under correctional supervision in the U.S.; by 1996 the number doubled to 859,400 (U.S. Department of Justice, 1999). Most women in the criminal justice system, regardless of offense, have substance abuse problems (Wellisch, Prendergast, Anglian, 1994). Despite the effect of drug abuse on women and their families, women's treatment needs tend to be overlooked and/or inadequately understood.

Research has shown that women differ significantly from men in terms of their pathways into crime and drug addiction (Daly, 1994) as well as their social and psychological characteristics (Wellisch et al., 1994; Wald, 1995). Symptoms of women's addiction are typically "inner directed" appearing as anxiety, shame, and depression, whereas male manifestations of addiction are more visible and external — drunk driving, fighting and assault (CASA, 1996).

The evidence with respect to the role that genetics plays in addiction is less clear for women than for men (Svikis, Velez, and Pickens, 1994). Women do, however, report more family history of drinking than do men (Finkelstein, Kennedy, Thomas and Kearns, 1997). Research on neurotransmitters such as dopamine and seratonin have largely been conducted on animals and have not distinguished effects by gender (Finkelstein et al., 1997; Wilcox, Gonzales, and Erickson, 1994). More research has been done on gender-specific physiological consequences of drug use. The phenomenon known as "telescoping" suggests that women experience more severe consequences of drug use over shorter periods of time than do men (Finkelstein et al., 1997; CASA, 1996; Blume, 1990; Nespor, 1990; Reed, 1987). Women's blood alcohol levels are higher than men's of the same weight for similar levels of consumption due to differences in gastric metabolism, differences in body fat and body water levels (CSAT, 1994; Deal and Gavaler, 1994). Adverse health consequences for women include increased risk for liver disease, sexual dysfunction, menstrual and pelvic problems, heart disease and breast cancer (Finkelstein et al., 1997; CASA, 1996). Of special concern is the growing incidence of HIV among women. Women face multiple risk factors for HIV, most of which relate to drug use (e.g., their own or sex partner's drug use, and their work as prostitutes in order to obtain drugs).

There are also unique social contexts to women's addiction that are in large part associated with

relationships with male partners and the greater social stigma attached to women's use of drugs. Women often begin their drug use as part of a common activity with boyfriends; female addicts are more likely than male addicts to have a partner who uses illegal drugs (Lex, 1995). Women also use drugs as a form of comfort or numbing at the demise of a relationship (Amaro, 1995). Violent and abusive relationships are strong contributors to female substance abuse. Women's roles as caretakers and nurturers may cause them to ignore or deny their drug abuse especially because they fear the loss of their children. Family reliance on the woman as caretaker often leads family members to deny or minimize the problem as well. Men's drug and alcohol use is more socially tolerated and sometimes condoned as acceptable "machismo" behavior whereas drinking and drugging on the part of women engender greater social disapproval and are considered antithetical to traditional female roles of mother and wife.

This social stigma also affects the ways professionals treat female addicts reflected by a reluctance to identify substance abuse problems in women or more punitive and negative attitudes toward female patients/clients (Chasnoff, 1989; Beckman, 1994; Finkelstein et al., 1997).

Treatment Issues

These contextual issues contribute to low self-esteem, poor coping skills, and mental health problems, notably depression, post traumatic stress disorder, eating disorders, anxiety and increased risk of suicide. Additionally, whereas chemical dependency knows no class or race boundaries, drug-addicted women who are involved in the court system most often come from poor and/or minority communities and experience myriad socioeconomic problems (Mitchell, 1993). These include lack of job skills and/or employment experience, limited access to transportation, lack of child care and homelessness. Therefore, effective treatment for women must be holistic, addressing not just drug use, but underlying problems that contribute to drug use and relapse. Services provided to women addicts must be set in a context that empowers them, improves coping skills, and helps them to develop functional support networks and greater life stability (Falkin, Wellisch, Prendergast, Kilian, Hawke, Natarajan, Kowaleswkis, and Owen, 1994). Effective programming for women builds on their strengths, i.e., a competency-based approach (Nelson-Zlupko, Kauffman, and Morrison, 1995), rather than the more traditional deficit model.

Additionally, it is important that program staff "can develop authentic, caring, and trusting" relationships with clients (Finkelstein et al., 1997). Treatment for women must recognize that women are not a monolithic genetic entity, but rather a diverse population with experiences and coping skills influenced as much by race, ethnicity, and class as by gender (Banyard and Graham-Bermann, 1993).

There is also growing agreement that women-only programs can best meet the needs of women who abuse drugs and alcohol (Morash and Bynum, 1995; Falkin et al., 1994; CASA, 1996). Treatment issues that are most important to women's abuse of drugs, such as domestic violence and sexual assault, are among the most uncomfortable to disclose in a coeducational group. Therefore, if the program is not for women only, it should offer extensive gender-specific treatment sessions. Peer support is also effective for women by providing supportive networks and role models for success. Similarly, case management is an especially effective service delivery strategy for women enmeshed in unstable, chaotic, and fragile lives and who are often involved in multiple systems including family court, social services, child welfare, public housing, their children's school systems, and the criminal justice system.

A Treatment Model for Women: The Crossroads Program

Crossroads is a substance abuse day treatment program for women offenders operated by the Center for Community Alternatives (CCA) to serve as an alternative to incarceration in New York City. Crossroads delivers a range of services intended to address holistic manner, while ensuring accountability to the courts and criminal justice system. Although the program relies heavily on a group model, individual case planning remains a critical program component. Case management and court advocacy assist clients in negotiating fragmented human services, child welfare systems, and Family Court to secure housing and entitlements and to address domestic violence and child custody issues. Crossroads provides the following services:

- group and individual substance abuse counseling;
- survivors groups (related to sexual abuse and domestic violence);
- HIV/AIDS services;

- acupuncture to aid in detoxification and relapse prevention;
- urinalysis;
- family groups;
- parenting groups;
- job readiness, vocational counseling, employment placement;
- life skills training;
- mental health counseling and medication (when warranted);
- family and criminal court advocacy services; and
- case management including referral to housing, health, prenatal and child care.

Participant and Staff Characteristics

Crossroads serves approximately 75 women a year. The socio-demographic characteristics of program participants are indicative of a population that has significant histories of substance abuse, physical and sexual abuse, and court involvement. As Crossroads is designed as an alternative-to-incarceration, all women who participate in the program are facing criminal charges at the time of their referral. The typical program participant is charged with a felony and has a prior criminal history. Roughly 55 percent of program participants are African American, 40 percent Latina, and 5 percent Caucasian. About 80 percent of participants have one or more children, and while half report loss of custody, almost all want to maintain or regain custody of their children. About one-quarter of program participants are HIV-infected and about 85 percent report past sexual and physical victimization.

Program staff have various professional degrees, but the majority are masters or bachelor level social workers and credentialed substance abuse counselors. Court advocates typically have law degrees or master's degrees in criminal justice. All counseling staff are trained in ear point acupuncture and the program also uses the services of a licensed acupuncturist. Other program consultants include a psychiatrist and a nurse practitioner. Most staff are women, but there are usually one or two men on staff. Staff are racially and ethnically diverse; approximately two-thirds of the staff are from communities of color, and several are Spanish speaking.

Program Operation

Crossroads employs a system of program phases that guides the nature of program contacts and requirements. Women remain in the program for six-to-twelve months, depending upon treatment needs and/or court mandate.
The three phases of Crossroads treatment are: (1) Assessment and Stabilization; (2) Decision-Making; and (3) Community Schedule. As the II, controls are lessened contingent upon demonstrated progress. Phase III focuses on community transition, employment or educational or vocational training, and the development of a community-based network of comprehensive aftercare.

A special program protocol for pregnant women makes prenatal care mandatory and case managers accompany pregnant clients to their initial visits with their medical provider and monitor subsequent visits. HIV prevention education and HIV/AIDS support services are high service priorities because of the high incidence of HIV infection among the Crossroads population and the characteristics that place virtually all program clients at high risk. HIV education groups are offered to all clients, and support groups and services are available to those clients who have already tested HIV positive.

Through recreational activities, such as picnics, movies, museums and plays, clients learn how to enjoy their free time and how to socialize with other sober individuals. Family activities are also important, particularly those that include the clients' children.

Criteria for successful completion or "graduation" include movement through the phases of the Crossroads program, compliance with program rules, and maintenance of sobriety. Clients who meet these criteria are eligible to graduate after eight to twelve months of program participation. Actions that can lead to program termination, such as rearrest, absconding from the program, continued drug use combined with refusal to comply with treatment recommendations, are evaluated in the context of the client's overall functioning. With judicial consent, Crossroads employs a range of methods and "graduated sanctions" before recommending that the client be terminated.

Outcomes and Benefits

The benefits of Crossroads are best illustrated through Mary's story. Mary, a 41-year old single

mother of two, was referred to Crossroads in June 1998, after being charged with a felony-level drug crime. Mary's substance abuse history began at age 13; upon her entry into Crossroads, she was snorting heroin, drinking alcohol and smoking crack daily. A relative had adopted Mary's 14-year old daughter, and her 4-year old son was in foster care. Mary was consumed with guilt and shame, which exacerbated her drug abuse. She relapsed in the early phase of her treatment and was referred to a detox program after which she returned to Crossroads. This proved to be the turning point in Mary's recovery and she became a very positive role model for her peers. After completing a 16-week vocational training program, Mary became employed and was reunited with her son, with whom she presently lives.

Conclusion

Mary's story is similar to many women who enter Crossroads. The savings are in human and financial terms. Last year Crossroads saved 71 years of incarceration resulting in a savings of $2 million. Investing in drug treatment for women offenders can save their lives and avoid the destructive consequences of imprisonment.

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This article was reprinted from the spring 2000 issue of The Source *newsletter and should be cited as Weissman, M. & O'Boyle, K. (2000). Women and Addiction: Treatment Issues and Innovative Program Models*. The Source, *10(1): 17-20.*