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Substance abuse treatment and care for women:

**Case studies
and lessons learned**

Drug Abuse Treatment Toolkit

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Vienna

Substance abuse treatment and care for women:

Case studies and lessons learned



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Preface

The present booklet is about gender-responsive substance abuse treatment services for women. It is part of the United Nations Office on Drugs and Crime (UNODC) project to develop tools to support the development and improvement of substance abuse treatment services, based on evidence from the literature and case studies that illustrate practical experiences and lessons learned in providing substance abuse treatment services in various regions of the world. Other publications in this Drug Abuse Treatment Toolkit series are: *Investing in Drug Abuse Treatment: a Discussion Paper for Policy Makers*; *Contemporary Drug Abuse Treatment: a Review of the Evidence Base*; and *Drug Abuse Treatment and Rehabilitation: a Practical Planning and Implementation Guide*.^{*} These can be found on the UNODC web site (www.unodc.org/unodc/en/treatment_toolkit.html).

The project on women's substance abuse treatment services was launched in response to the Declaration on the Guiding Principles of Drug Demand Reduction (General Assembly resolution S-20/3, annex) and the measures to enhance international cooperation to counter the world drug problem (Assembly resolutions S-20/4 A to E), adopted by the General Assembly at its twentieth special session. The Guiding Principles indicate that demand reduction programmes should be designed to address the needs of the population in general, as well as specific population groups.

In most countries of the world, the circumstances of women's lives are very different from those of men. This is also reflected in their experience of substance use problems. Women's substance use problems are more stigmatized and less likely to be acknowledged than men's. As a result, much less is known about the prevalence and patterns of women's substance use, and

their treatment needs. Women with substance use problems also experience significant barriers to accessing treatment, and are believed to be underrepresented in treatment settings. Cultural taboos and stigma mean their substance use problems are often not acknowledged by themselves, their families or helping professionals who could support them in seeking treatment. Pregnant and parenting women using substances face particular societal condemnation, and pregnant women often delay seeking services with serious implications for the mother and the foetus. Women who are parents usually have primary responsibility for childcare, as well as other household responsibilities. However, few treatment services provide childcare, and in some cultures it is very difficult for women to leave their homes and family responsibilities to seek treatment.

More often than men, women have been introduced to substances and continue to use substances with their spouses or partners, who may also be physically or sexually abusive. With little emotional support, or financial resources to pay for treatment, childcare or transportation, women find it difficult to enter and remain in treatment. Women also have more severe problems at treatment entry than men. Many have experienced trauma and use substances to cope with these experiences. They are more likely to have mental health problems such as anxiety or depression or post-traumatic stress disorder than men. They also have fewer resources in terms of education, employment and finances. At the same time, because more men than women use illicit and other substances of abuse, most treatment programmes have been designed with men in mind and do not take into account gender differences. The goal of this publication is to raise awareness about the treatment needs of women and to provide tools, suggestions and practical

^{*}United Nations publication, Sales No. E.03.XI.II.

examples for overcoming access barriers, engaging women in treatment and providing treatment that is responsive to the specific needs of women.

The booklet brings together information from a variety of sources:

- A review of the literature. Published articles and reports were identified through a search of Medline/PubMed, EMBASE and PsychInfo databases from 1998 to 2003; as well as from web sites of international and national bodies and organizations that contain guidelines, full text articles or other relevant information. Members of an international panel of experts formed to advise on various phases of the project and representatives of case studies included in this booklet were also a rich source of articles, reports and other information. The literature review built on several other recent literature reviews, particularly the literature review by Gillian Hunter, which formed part of a Pompidou Group report: *Problem drug use by women: Focus on community-based interventions** and *Best Practices: Treatment and Rehabilitation for Women with Substance Use Problems.***
- Case studies provide practical examples and experiences that illustrate findings from the literature. Recommendations for case study projects were obtained from the following sources: United Nations Office on Drugs and Crime headquarters and its various field offices; members of the expert panel; international organizations represented on the expert panel, including the World Health Organization/Pan American Health Organization (WHO/PAHO); the Inter-American Drug Abuse Control Commission (CICAD); the European Monitoring Centre for Drugs and Drug Addiction (EMCDDA); and databases and reports describing women's substance abuse treatment projects. Case studies chosen for inclusion in the present publication illustrate the major topic areas of women's substance abuse treatment and reflect the experiences of different regions of the world. While many projects providing gender-responsive substance abuse treatment were identified in Australia, the European Union and North America, efforts to identify a more representative sample of projects in other regions were not as successful.

- Presentations and discussions that took place at a meeting of representatives of case study projects, members of the international panel of experts and staff of the United Nations Office on Drugs and Crime, entitled "Women's Drug Treatment: Lessons Learned" held in Vienna, from 15 to 17 December 2003, referred to thereafter in the following chapters as "the Vienna meeting".

The present publication is about substance abuse treatment for women in general. Though it is recognized that adolescent women and older adult women have specific treatment needs because of their different substance use patterns and life circumstances, treatment and rehabilitation issues for these two population groups will be addressed in more depth in other publications of the United Nations Office on Drugs and Crime in the Drug Abuse Treatment Toolkit series. Prevention is an extremely important aspect of addressing women's substance use as well. However, consideration of gender-responsive prevention interventions is beyond the scope of this publication.

The main focus of the publication is on the treatment of women using illicit substances, which accords with the mandate of the United Nations Office on Drugs and Crime. However, it is recognized that alcohol is also an illegal substance in some countries and that women with substance use problems are often poly-substance users. As well as using illicit substances, women may be drinking harmfully and are more likely than men to use central nervous depressant drugs such as benzodiazepines and other sedative-hypnotics. Many women who use psychoactive substances also smoke tobacco. Though the focus of this publication is on illicit substances, the approaches and recommendations are also relevant for women with alcohol problems. In many countries, alcohol and illicit substance use problems are treated in the same setting, generally using the same methods. However, this is not true of tobacco, which the substance abuse treatment field is starting to recognize as a significant problem for their clients.

The report, *Global Illicit Drug Trends, 2003*,*** indicates that, while cannabis is the most widely used illicit substance, it is not the substance that generates the most demand for treatment. Rather, opiates compose the most serious problem substance in the world and gener-

*D. Hedrich, *Problem drug use by women: Focus on community-based interventions* (Strasbourg, Pompidou Group, 2000) (available at www.coe.int/T/E/Social_Cohesion/pompidou_group/5.Publications/).

**Health Canada, *Best Practices: Treatment and Rehabilitation for Women with Substance Use Problems* (Ottawa, Minister of Public Works and Government Services, Canada, 2001) (available at www.cds-sca.com/).

****Global Illicit Drug Trends, 2003* (United Nations publication, Sales No. E.03.XI.5) (available at www.unodc.org/pdf/trends2003_www_E.pdf).

ate the most illicit drug treatment demand overall. In Asia, Australia and Europe, the greatest treatment demand is for opiate abuse (though methamphetamine abuse is generating the most treatment demand in South-East Asia). In North and South America, cocaine abuse generates the most treatment demand, with heroin almost equalling cocaine in North America. The exception is Africa, where the greatest treatment demand is for cannabis. Recent data indicate the upsurge of cannabis-related treatment demand in North America and Europe.

“Gender-responsive” is a term that is used frequently throughout this publication. Gender-responsive programmes are those that consider the needs of women in all aspects of their design and delivery, including location, staffing, programme development, programme content and programme materials.

The first chapter of the publication describes the physiological and psychological aspects of women’s substance

use and reviews studies on treatment entry, completion and outcomes. Where literature is available, gender differences in these areas are discussed. Chapter 2 describes barriers that women experience in accessing treatment. Chapter 3 discusses methods for promoting gender-responsive treatment, and chapter 4 describes strategies such as awareness, training, outreach and low-threshold services that can overcome barriers to treatment engagement. Chapter 5 describes various aspects of providing gender-responsive treatment services specifically for women, including theory and principles, organizational issues, psychosocial and pharmacological interventions and treatment issues for pregnant and parenting women. Case studies from various regions of the world provide practical examples of findings from the literature and from discussions at the Vienna meeting. The reader will note that the style and language varies from case study to case study, which reflects the fact that, as far as possible, the views and expression of each implementer towards treatment and their work has been maintained.

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Executive summary

This publication concerns treatment for substance abuse by women that is gender-responsive and forms part of the United Nations Office on Drugs and Crime (UNODC) project to develop tools to support the development and improvement of substance abuse treatment services. Gender-responsive programmes consider the needs of women in all aspects of their design and delivery, including location, staffing, programme development, programme content and programme materials.

This publication is designed to raise awareness of the treatment needs of women. It provides tools, suggestions and practical examples for overcoming access barriers, engaging women in treatment and providing treatment that is responsive to the specific needs of women. It brings together information from the literature, from case studies of women's services in different regions of the world and from presentations and discussions that took place at a meeting of international experts, representatives from case-study projects and UNODC staff held in December 2003. The primary focus of the publication is on illicit substances, since that is the focus of the mandate of UNODC.

It is difficult to get a full picture of women's use of substances and its associated problems, since prevalence studies and biological, prevention and treatment research studies may not address gender issues. The available literature indicates that women are generally less likely than men to use illicit substances, gender differences in illicit substance use being much smaller among adolescents. In contrast, women are more likely than men to use pharmaceutical drugs both medically and non-medically. In terms of physiological differences, there is evidence that women, in comparison with men, may become dependent more quickly on a number of illicit substances, may engage in more HIV-risk behaviours and have higher mortality rates if they inject drugs. Psychoactive substances often affect

and are affected by different phases of women's menstrual cycle. Substance use during pregnancy can result in low birth weight, early delivery and poor nutritional status. However, some of the effects on the mother and the foetus may also be attributed to the lifestyle associated with illicit substance use.

Generally, women with substance use problems have fewer resources (education, employment, income) than men, are more likely to be living with a partner with a substance use problem, have care of dependent children and have more severe problems at the beginning of treatment. Women with substance use problems also have higher rates than men of trauma related to physical and sexual abuse and concurrent psychiatric disorders, particularly post-traumatic stress disorder and other mood and anxiety disorders. Available information indicates that women are underrepresented in treatment, though information from many countries is lacking. Some studies indicate that women are less likely to enter and to complete treatment than men, while others have found no differences. Treatment-outcome studies have generally found no gender differences. However, studies of comprehensive or enhanced treatment programmes specifically designed to meet women's needs have found improved outcome.

Women encounter significant systemic, structural, social, cultural and personal barriers in accessing substance abuse treatment. In most countries of the world, women are underrepresented in positions of power that influence awareness of gender differences, policy development and resource allocation. There is limited information about women with substance use problems and lack of appropriate evidence based on low-cost treatment models for women.

At the structural level, the most significant obstacles include lack of childcare and punitive attitudes to

parenting and pregnant women, which makes them fear losing custody of their children and prevents them from seeking treatment early enough. Often women do not have money to pay for transportation, childcare costs or treatment. Treatment programmes may be located far from where women live and may have inflexible admission requirements and schedules.

In many societies, problems of substance use and women's use of substances are heavily stigmatized and cultural norms may make it difficult for women to acknowledge such a problem or leave their homes and families to have treatment. Because many women with substance use problems also live with a partner or other family members with a substance use problem, it is even more difficult for them to obtain support to undergo treatment.

Gender-responsive services for women have been promoted at the international, regional and national levels through policy statements; through inclusion in national drug strategies; through the development of treatment best-practices, guidelines and standards, symposiums and reports; and through the dissemination of information on model programmes.

Much more is now known about strategies that help overcome the significant hurdles that women encounter in accessing and remaining in treatment. What has proved particularly successful in societies with strong cultural taboos and sometimes few resources is informing and educating communities about the issue and training community members, especially women in the community, in prevention-and-treatment support activities. Training other helping professionals, particularly primary-care providers, and networking and linking with health and social service providers can help in the identification and referral process of women with substance use problems. It also helps to ensure that clients can access the services they require. Particularly crucial are collaborative relationships with prenatal, child welfare, mental health and crisis services.

Gender-responsive programming for women considers women in all aspects of programme development, design and delivery. Gender-responsive programmes should be based on a unifying theory and set of principles in order to provide a framework for the programme environment, programme content and materials and to ensure that staff share the same beliefs and values about treatment for women.

Programme organization and setting are important aspects of planning and developing programmes for women. The programme may be an autonomous women-

specific programme; it may be women-specific but part of a larger organization; or it may include components for women only as part of a mixed-gender programme. Women in leadership positions in governance and programme administration can be role models for clients.

The focus of outreach services, including peer outreach approaches, is on reaching women who are not in contact with other services and particularly those who inject drugs and are engaged in sex work. However, outreach services can also be used to engage and support women who are in contact with other services but who require accessible substance abuse treatment. In some situations, peers—women in the substance user's community or women who are former or current substance users—play a role in outreach or low-threshold services.

Low-threshold services are also designed to reach vulnerable clients. Women who use low-threshold services may need a safe place, away from violence, as well as the other practical supports provided by such services, such as clean injecting equipment, safer sex aids, food, shelter and clothing.

Whether at low-threshold or at structured treatment services, it is necessary to ensure that the programme environment is safe for women, particularly in mixed-gender residential services, and that staff have the necessary skills in training and support. Careful consideration should be given to employing male staff and evaluating their role in women's treatment. Although some women require residential services, community-based outpatient or day services have many advantages in terms of being more accessible and less costly. Aftercare and social reintegration components, particularly skill development, employment training and housing, are critical for many women.

A comprehensive assessment ensures the development of a client-centred treatment plan and should focus on issues concerning partners and family relationships and responsibilities, pregnancy, high-risk behaviours, trauma history and mental health problems; it should also include the client's readiness to participate in treatment, possible inclination to suicide and the possible obstacles involved in participating in treatment.

Recent research has supported clinical knowledge about the effectiveness of comprehensive or enhanced treatment for women, including components such as women-only treatment, childcare, prenatal care, parenting skills and workshops that address women-only topics. Psychosocial treatment for women needs to address affective, cognitive and behavioural dimensions, including coping

skills, relapse prevention, relational work, trauma and other concurrent mental-health problems. Attention to practical issues such as medical care, employment, food, clothing and transportation is also necessary.

Opioid substitution treatment, particularly methadone maintenance, has received extensive support in the literature as reducing the use of illicit substances and associated problems and increasing life functioning for opioid-dependent individuals. It is the treatment of choice for opioid-dependent pregnant women. However, opioid substitution treatment should not stand alone, but rather be complemented by other services that address women's needs.

Engaging and retaining pregnant and parenting women in treatment requires collaboration between the substance abuse treatment sectors of prenatal care and child

welfare. Appropriate interventions for pregnant and parenting women can reduce substance use and improve outcomes for pregnant women and increase treatment retention for women who retain custody of their children and/or have their children with them in treatment. Ideally, services should be accessed through a single site.

Little is known about women with substance use problems, their treatment experiences and effective treatment models and interventions in different political and sociocultural contexts. It is thus important that programme planning and implementation include a systematic needs assessment and that programme monitoring and evaluation activities be built into the programme design. There is still a need for quantitative and qualitative research on effective interventions for women and also on how to adapt them to different countries.

1. Women, gender and substance use problems

The content of this chapter concerns what is known about women's substance use and related problems, treatment characteristics, experiences and outcomes, and how they differ from those of men. It is difficult, however, to get a full picture of women's substance use, since international, national and local studies on the prevalence of substance use and associated problems do not often address gender issues. As noted by Murthy [1], women with substance use problems may not show up in official statistics in some countries, such as India, because of their small numbers and subordinate position in the drug culture. This is consistent with the historical focus on men in the field of substance abuse [2].

Lack of resources, lack of awareness and negative attitudes to women's substance use may contribute to the scarcity of gender-related epidemiological data and other research on women's substance use problems. In addition, methodological problems contribute to women not being included in some research studies and/or the absence of gender analysis, as female physiology is more complex than male, e.g. "risk" of pregnancy, higher co-morbidity, especially in older women, and changes in hormonal levels with the menstrual cycle and pre- or post-menopause. Lack of information about women and gender differences is particularly true of regions such as Africa, Asia and Latin America [1]; and it should be noted that the majority of studies discussed in this chapter, particularly on treatment experiences, are from the United States of America, with some also from Australia, Brazil, Germany and the United Kingdom of Great Britain and Northern Ireland. Thus, it may not be appropriate to generalize the findings to other countries.

Prevalence of substance use

The most recent United Nations report that discusses gender differences with respect to substance abuse,

Global Illicit Drug Trends, 2002 [3], indicates that women represent an estimated 10 per cent of substance users in some traditional Asian societies, 20 per cent in countries of the former Union of Soviet Socialist Republics and Latin America and about 40 per cent in North America and some European countries. Though rates of women's substance use may be low in comparison with men, reports from Australia, the United States, Canada, and countries in the European Union indicate a convergence in rates of use of some illicit substances among young men and young women and increasing rates of the use among women in general in some European countries. A publication, *Revisiting "The Hidden Epidemic": a Situation Assessment of Drug Use in Asia in the Context of HIV/AIDS* [4], also reports an increase in substance use among Asian women and an increased involvement of women injecting drug users in sex work in many Asian countries. The intersection of injecting drug use, sex work and unsafe sexual practices has become a significant factor in the increased risk of HIV among women, particularly in Asia, Eastern Europe and North America.

Although the prevalence of illicit substance use may be lower among women than men, women are more likely to use pharmaceutical drugs (both illicit and prescribed), the highest rates of use, at least in Europe and North America, occurring among older women.

Physiological effects and consequences

Information on gender differences in the physiological effects of substances is limited. There is evidence, however, that for some substances, such as alcohol and tobacco, women may be more vulnerable than men to both the acute and long-term effects. For example, with consumption of the same amount of alcohol, women achieve higher blood alcohol levels than men, and studies on the long-term effects of alcohol have

BOX 1WOMEN AND SUBSTANCE USE IN DIFFERENT REGIONS OF THE WORLD

Afghanistan: Among Afghan women, there has been a reported rise in substance use, particularly among women who are refugees, many using a daily combination of opium (eaten, drunk or smoked) and pharmaceuticals. These substances are readily available in Afghanistan and in refugee camps in Pakistan to self-medicate physical and mental health problems. Nearly one in five female substance users are over the age of 50 [5].

Australia: Based on 2001 data, the use of illicit substances is more common among men than women (41.3 per cent versus 34.2 per cent), except for the youngest age group. Among 14- to 19-year-olds, 37.4 per cent of males and 37.9 per cent of females report they have ever used an illicit substance. In this same age group, female rates of ever having injected a substance exceed those of males (1.7 per cent versus 1.0 per cent). Illicit substance use is most common among those in the age group 20-29 years, with 65.2 per cent of males and 59.9 per cent of females reporting they had ever used an illicit substance. Prevalence rates for substance use disorders in the Australian population were 3.1 per cent among males versus 1.3 per cent among females; of those, 46 per cent of women and 25 per cent of men had a concurrent disorder [6, 7].

Brazil: A household survey of substance use in 24 large cities in the state of São Paulo found the male:female ratio of cannabis use to be 3.5:1 and that of cocaine use to be 4:1. For stimulants, the ratio was 0.3:1 and for benzodiazepines, it was 0.6:1. However, the study also found a higher proportion of females than males initiating cocaine use, suggesting a potential increase in cocaine dependency among women (Carlini and others cited in [8]).

Chile: Though the rates of lifetime and recent use of illicit substances are higher among men than women, the rates of dependency on cocaine, and on cocaine-base paste, are higher among women. Rates of use of illicit substances have remained stable over the last several years, with a decrease in rates of use of cannabis products and cocaine-base paste among adolescents, particularly adolescent women. However, alcohol use has increased more among women than men in this age group [9].

China: Among the population overall, the number of registered drug users has risen rapidly through the 1990s [4], with the actual number of users believed to be much higher than those registered. Rates of injecting range from just over 50 per cent to as high as 80-90 per cent of registered drug users in some provinces. The number of women using substances is also increasing and many women substance users are also involved in prostitution to support their habit. The second national epidemiological survey on illicit substance use, conducted in six high-prevalence areas in China, found that among women the lifetime prevalence of illicit substance use was 0.57 per cent and the rate among men was 2.58 per cent. Rates of use for the previous 12 months were 0.48 per cent for women versus 1.80 per cent for men. The most frequently used illicit substances overall were opiates, primarily heroin, followed by opium, though no gender breakdown was reported by type of drug [10].

Germany: It is estimated that about 15-25 per cent of the "hard-core" substance users (those using illicit drugs other than cannabis) are women, most of whom are poly-substance users with a preference for heroin. However, crack use is increasing among women in their twenties, as well as those in their mid-thirties and older [11, 12].

European Union: In the European Union countries, as in many other regions of the world, national rates of illicit substance use are lower among women than men, while rates of use of licit and illicit medications such as benzodiazepines are higher. However, gender differences in rates of cannabis use among teenagers (15-16 years) are small or non-existent, and girls appear to initiate the use of experimental substances at a younger age than boys. Though women commit fewer property crimes than men, sex work is a source of income for up to 60 per cent of female substance users in the European Union [13].

India: Although the majority of substance users in India are male, use of heroin has increased among women in different cities in India. In a rapid assessment survey conducted in 14 cities in India in the period 2000-2001, women substance abusers represented a mean of 7.9 per cent of the sample, heroin, alcohol, cannabis and painkillers being the dominant substances of abuse. Typically, female substance users in the study were single, educated and employed and reporting an early onset of substance use. They were also engaged in unsafe practices such as early initiation into sex and sharing injecting equipment [1]. Another study [1] involving interviews with 75 women substance users in three cities in India found that the predominant substances of abuse were heroin, propoxyphene, alcohol and minor tranquilizers. A few women reported using cannabis and cough syrup. The primary reasons reported by the women for initiating substance use were influence of friends, stress and tension, and influence of spouse or partner. Almost half of the women were engaged in sex work to obtain money for drugs and almost a third were engaged in selling drugs.

Iran (Islamic Republic of): A rapid situational assessment of drug use in 1999 carried out by the United Nations Office on Drugs and Crime and the Islamic Republic of Iran estimated that 6 per cent of the 800,000-1,200,000 substance users were women [14]. It is also believed that substance use among women is increasing rapidly [4]. Common substances of abuse in the Islamic Republic of Iran are opium, opium residue, heroin and cannabis. Only about 5 per cent of women substance users reported injecting drugs—mainly women aged between 22 and 30 years and involved in sex work. The interval between first substance use and injecting averages 2.5 years (in contrast to 8 years for men). Only about 5 per cent of those in treatment are women [15, 16].

Kenya: A study of heroin users in one Kenyan coastal town [17, 18], estimated the ratio of men to women heroin users to be 20:1. Many of the women heroin users worked in the sex trade industry. The same study estimated that overall 50 per cent of heroin users injected heroin.

Russian Federation: Official statistics indicate that the annual number of women first registered with a diagnosis of drug addiction during the period 1993-1999 increased 10 times in the Russian Federation and 16 times in Moscow. In a study of 80 women admitted to two treatment programmes for heroin addiction, it was found that the time period between starting heroin use and seeking treatment was shorter for women than in a comparison group of men; women were four times more likely than men to have used heroin as their initial substance of abuse and often proceeded to injecting without previous intranasal use [19].

United States of America: In the 2002 National Survey on Drug Use and Health [20], among the population aged 12 or older, 6.4 per cent of women versus 10.3 per cent of men reported current (past month) illicit substance use. However, rates of non-medical psychotherapeutic substance use were very similar: 2.6 per cent for women and 2.7 per cent for men. Among 12-17-year-olds, 12.3 per cent of boys and 10.9 per cent of girls reported past month use of "any illicit drug". However, girls reported higher rates of use of psychotherapeutic substances non-medically than boys (4.3 per cent versus 3.6 per cent) [20].

shown that women are at greater risk than men of developing liver damage, brain damage and heart disease [21-23]. A recent study, however, shows that older women achieve a higher alcohol blood concentration than younger women, which points out that age might be more of an indicator than gender. Similarly, studies on tobacco have shown that women smokers are at higher risk for long-term health consequences such as lung cancer and heart problems, than men [2]. Not as much is known, however, about gender differences in the acute effects and long-term consequences of illicit substances [24], although psychoactive substances often affect and are affected by different phases of women's menstrual cycle [2, 25].

Cocaine

There is evidence of some gender differences in both the acute effects and longer-term consequences of cocaine. For instance, research by Lukas and colleagues [26] has found that men may be more sensitive than women to the acute subjective effects of cocaine. As well, although women's cocaine plasma levels differed during different phases of their menstrual cycle, this did not result in different levels of sensitivity to cocaine's effects. This same study also suggested that women may be more sensitive

than men to the acute cardiovascular effects of cocaine. In terms of longer-term consequences, one study found that males with less lifetime exposure to cocaine than women were more vulnerable to brain damage. It was hypothesized that female hormones may protect women against such damage [27]. Studies have also found similar levels of cognitive impairment in men and women, even in cases where women had greater lifetime exposure to cocaine. Cocaine has also been found to disrupt women's menstrual cycle and affect fertility [2, 28, 29]. Gender differences have also been found in animal studies that have looked at self-administration of drugs, finding that females self-administer sooner and in larger amounts than males and that self-administration in females was affected by changes in hormonal levels [30].

Opioids

Similar gender differences have also been found in animal studies of heroin self-administration. As well, dependence on heroin occurs more quickly among women than among men (see below) [28].

In terms of longer-term health consequences, literature does not indicate gender differences associated with injecting opioids such as damage to veins, bacterial

infections, abscesses, cellulites or liver and kidney disease [24]. Some studies point out that women who inject opioids seem to be at higher risk of HIV infection [31, 32], and women who inject drugs appear to experience higher mortality rates than men (see below). Like cocaine, heroin also interferes with women's menstrual cycle. Women using opioid drugs may experience secondary amenorrhea and be at risk for unplanned pregnancies [33]. Because women may be unaware that they are pregnant, they may delay seeking prenatal care [34].

Benzodiazepines and other sedative-hypnotics

According to available epidemiological data, women are more likely than men to engage in non-medical use [35] and to meet the criteria for lifetime dependence (based on the third edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM III-R)) on substances such as tranquilizers and sedatives used non-medically [36]. However, there is little evidence that there are gender differences in the acute effects or longer-term consequences of these types of substances.

Dependence

As noted above, animal research has found gender differences in self-administration of some drugs. Research has also shown that, although there are no gender differences in the development of heavy substance use following first administration, women typically become dependent on substances such as cannabis, cocaine and other stimulants, opioids, inhalants, hallucinogens and central nervous system (CNS) depressant substances more quickly than men. That is, though women have used these substances for a shorter period, their rates of dependence are similar to men's [2, 25, 28, 37]. Knowledge of gender differences in factors, which are responsible for development of substance dependence, might be important for effective drug prevention. Research also indicates that men generally have more opportunities to use illicit substances than women. However, given the same opportunities, men and women are equally likely to use substances and to progress from initial use to addiction [28].

Injecting drug use and risk of blood-borne diseases

Studies indicate that women who inject drugs may engage in more HIV risk behaviours and also have higher mortality rates than men. Women more often than men have a sexual partner who injects drugs and who is also

the primary source of shared needles [38]. Women also share injecting equipment with more people in their social network than men [39]. In countries such as the former Union of Soviet Socialist Republics, where group injecting is common, women may be the last to use the needle/syringe [40]. These behaviours also put women at risk for other blood-borne diseases such as hepatitis; with rates of hepatitis C virus (HCV) being very high among injecting drug users [41, 42]. In a study of injecting drug users in Vancouver, Canada, Patrick and others [42] found that being female was one of several factors (cocaine use, frequent injection) associated with HCV seroconversion.

Studies have explored factors that contribute to HIV seroconversion among women injecting drug users [43, 44]. In Vancouver, Canada, where HIV rates are higher among women than men, risk factors for seroconversion among women were injecting cocaine one or more times per day, requiring assistance to inject, having unsafe sex with a regular partner and having an HIV-positive partner [44]. Bruneau and colleagues [38] examined sex-specific determinants of HIV infection among injecting drug users in Montreal. For both genders, a history of sharing needles with a known HIV-positive partner and sharing in the past six months were associated with HIV infection. In addition, for women, obtaining their needles from "shooting galleries" and being out of treatment were associated with HIV infection; for men factors were related to sexual orientation, drug of choice (cocaine rather than heroin) and source of needles (pharmacy or needle exchange programme). A study in five cities in the European Union [42] found that, in addition to injecting behaviour (even shared injecting equipment), sexual behaviour was the strongest determinant of HIV. This included having a partner who was HIV-positive, commercial sex work and being co-infected with a sexually transmitted disease (STD). Other determinants were related to age, educational level, homelessness and previous imprisonment. In addition to engaging more in HIV-risk-related behaviours, once infected with HIV, women progress to AIDS more quickly than men [28].

An Italian study that examined a cohort of 4,200 injecting drug users (IDUs) enrolled in methadone maintenance programmes found that the mortality rate for the entire cohort was 10.1 but there was a significant gender difference of 9.3 for males and 18.1 for females [45]. The large excess of mortality in both sexes was found for infectious, circulatory, respiratory and digestive diseases, as well as for violence, overdose and AIDS. There was an increased mortality among the women for pneumonia and septicaemia and for malignancies in males. A later

study in Scotland that retrospectively examined 1989 data on injecting drug use and mortality also found a significantly higher mortality for female IDUs (0.85 per cent for women compared with 0.42 per cent for men) over a period of one year [46]. This represents a relative mortality risk for female IDUs compared with female non-IDUs of four times higher but only 1.5 times higher for male IDUs compared with non-IDUs.

Pregnancy and substance use

Use of illicit substances during pregnancy can result in low birth weight, early delivery and poor nutritional status [33, 47]. Some of these consequences may be due to the lifestyle associated with substance use such as poor nutrition, lack of medical and social care, and infectious diseases such as HIV/AIDS and hepatitis, which may compound any direct effects of illicit substance use on the health of the mother and the foetus.

For women who use heroin or other opioids during pregnancy, changes in the level of opioids in the blood can result in withdrawal, the risk of miscarriage, pre-term delivery or a small (for gestational age) baby and neonatal abstinence syndrome [33, 47].

For women who use cocaine during pregnancy, consequences for the mother and the foetus can include high blood pressure, heart problems, stroke and sudden death, premature rupture of membranes (PROM), shorter gestational age, reduced birth weight, placenta previa and separation of the placenta from the uterus, causing severe bleeding and death of the foetus. Some teratogenic effects have also been reported [33, 47].

Cannabis use during pregnancy has been found to result in a shorter gestational period and decreased maternal weight gain, with tremors and altered visual responsiveness reported in newborns of heavier cannabis users [33, 47].

Psychosocial risk factors and consequences

The profile of women who come to treatment is different from men in terms of demographics, substance use history and the types and severity of associated problems.

Demographics and substance use history

Based mainly on United States research [37, 48-53], but also including studies of treatment seekers from Brazil

[8] and the United Kingdom [54], studies have found that, when compared with men, women seeking treatment are:

- (a) Younger;
- (b) Less well educated, with lower income;
- (c) Less likely to be: employed, living alone or involved with the legal system (though among those women who are involved with the legal system, substances may be a significant factor in their crimes);
- (d) More likely to be: a housewife, married or living as married; have children living with them; have a substance-using partner; have been introduced to substances and injecting-drug use by their partner; have a sex partner who is also an injecting-drug user with whom they inject; have employment and family or social problems; have health problems; have a family history of alcohol or other drug problems; have a drug-only diagnosis as opposed to alcohol and drug diagnoses; and have a shorter period of time between onset of substance use and treatment entry.

In the Brazilian treatment sample, there were no age differences between men and women, and women were better educated than men. The authors [8] suggest that the lack of age difference between men and women may be because of the difficulty that women have in accessing treatment in Brazil, which reinforces the need to be cautious in generalizing findings from one country to another.

It should also be noted that in many parts of the world, particularly those undergoing economic restructuring, economic difficulties have led women to turn to activities such as sex work and drug trafficking to survive. This may fuel an existing substance use problem or lead women to start using substances [1, 40].

Trauma and concurrent disorders

Physical or sexual abuse of women is often perpetrated by a male partner or other male family members, and is a worldwide problem [55-58]. Studies show that women with substance use problems are more likely than men to have experienced physical and/or sexual abuse [51, 53, 59]. A history of violent assault can increase the risk of substance use and post-traumatic stress disorder or other mental health problems. Substance use can also increase the risk of further assaults [60-62].

Research indicates that women abused as children are significantly more likely to have used illicit substances

than non-abused children [63]. Hien and others [64] report that women abused as children have an earlier onset of substance dependence. A report from the United States National Evaluation Data Services [65] notes that, among United States women with substance use problems, 90 per cent have been sexually abused at least once in their lives and 50 per cent have been physically abused at least once in their lives. Rates in other countries may be lower.

An Australian national study of women clients of alcohol and other drug services reported that slightly over one third of the sample had been sexually abused as children (37 per cent), most frequently by male relatives (67 per cent). A smaller proportion had experienced physical abuse as children (21 per cent), while more than one third of women had been sexually abused as adults (35 per cent), most often by their sexual partner or strangers. Slightly more women had been physically abused as adults (38 per cent) [66]. Similarly in Germany, 50-60 per cent of women dependent on illicit substances other than cannabis were reported to have a history of physical and sexual abuse, with sexually abused women more often being poly-substance users [67, 68].

The experience of trauma can lead to the development of post-traumatic stress disorder (PTSD), or other mental health problems. Rates of PTSD among women in substance abuse treatment range from 30 to 59 per cent [69, 70]. PTSD has been associated with greater vulnerability to be re-traumatized and generally poorer treatment adherence and outcome [64, 70-72].

Studies have also found that compared with men, women with substance use problems report higher rates of psychiatric symptoms or diagnosed psychiatric disorders, most commonly anxiety, depression (though gender differences in rates of depression among individuals with substance use problems are smaller than among the population in general), borderline personality disorder and eating disorders [6, 73, 74]. Studies have also reported that women have higher rates of suicidal ideation and suicide attempts than men [73]. In contrast to women, men are more likely to be diagnosed with an anti-social personality disorder [74].

Men and women also differ in the sequence in which concurrent disorders develop [75, 76]. Research by Brady and colleagues has found that for women, psychiatric disorders, such as depression, panic disorder and PTSD, were more likely to precede the onset of a substance use disorder, while for men, depression at least was more likely to be a consequence of substance use, particularly cocaine and alcohol use. Robbins [77] has

concluded that substance abuse is related more strongly to problems such as depression, irritability and anxiety in women and to problems of social functioning such as employment, financial and legal problems among men.

Severity of drug problems

Studies have found gender differences in the severity of problems at entry to treatment specifically related to the frequency of substance use at that time and the scores on measures of problem severity.

In a study of admissions to publicly funded substance abuse treatment in one United States city [48], it was found that women had a higher composite score on all domains of the Addiction Severity Index except legal when compared with male admissions. Similarly, Acharyya and Zhang [49], using data from the United States Drug and Alcohol Treatment Outcome Study (DATOS), found that women were more likely than men to be heavy or very heavy users of the primary drugs of choice—heroin and cocaine—and had higher scores on a Problem Severity Index than men. Similarly, Stewart and others [54] found that women in a United Kingdom treatment sample reported more health problems and had greater frequency of cocaine use. Wechsberg and others [53], also using DATOS data, found that while men were more likely to be both daily and weekly users of alcohol and marijuana, women were more likely than men to be daily users of cocaine and heroin, except among those receiving methadone treatment. Women's use of sedatives or barbiturates, amphetamines and other opioids were also somewhat greater than men's.

Treatment entry, completion and outcome

Though information is lacking on the extent of problem substance use among women in most regions of the world, many researchers and practitioners believe that women are underrepresented in treatment settings. Some information on the proportion of women in treatment in various regions and countries is given in box 2.

Studies indicate that women encounter multiple barriers to treatment access, have more severe problems at treatment entry, and are more likely to seek treatment for their substance use problems in mental health facilities than in substance abuse treatment settings [2]. Thus, it would not be surprising if women were underrepresented in treatment, had lower rates of treatment completion, and less positive outcomes than men (bearing in mind that treatment retention and completion are strongly associated with treatment outcomes [81]).

BOX 2WOMEN IN TREATMENT

Australia: In Australia, 44 per cent of all treatment episodes in the period 2001-2002 were provided to women, an increase from 35 per cent in 1999. Women were significantly younger than men and were more likely than men to have heroin or benzodiazepine problems, while rates for amphetamines and cocaine were similar for both genders [78].

China: Consistent with increasing rates of substance use among women in China, it has been reported that in some provinces (Yunnan and Guangxi) women make up from 16-25 per cent of those in treatment. The age of women in treatment has also decreased in some provinces. In Guangxi, for example, many of them are as young as 17-18 years of age [4].

European Union: In the European Union, information obtained on outpatient treatment admissions in Denmark, Finland, Germany, Greece, the Netherlands, Spain and Sweden indicates that 20.8 per cent of new clients in 2001 were women. In terms of gender differences in problem substances, almost a third of stimulant users (32.5 per cent) were women; this contrasts with 18.8 per cent females for opiates, 15.0 per cent for cocaine and 14.2 per cent for cannabis [79]. In Germany, women are overrepresented in some treatment sectors such as opioid substitution treatment, but underrepresented in residential care [12].

India: In substance treatment centres, the proportion of women ranges from 1 to 10 per cent, but this may be an underrepresentation because of the greater stigma for women and also because of their childcare responsibilities [4].

United States of America: Women represented 30.4 per cent of treatment admissions in 2002 for all substances, including alcohol. Based on the percentage breakdown of primary substance of abuse within each gender, men were more likely to be in treatment for alcohol (53.3 per cent of men versus 39.6 per cent of women), whereas women's treatment was more likely to be associated with heroin, cocaine, stimulants and tranquillizers. Of women, 41.7 per cent reported having used an illicit drug at some time in their lives, based on the 2002 National Survey on Drug Use and Health; 46 per cent of drug-related visits to emergency departments in the period 2000-2002 were by women, a 22 per cent increase from 1995; and women accounted for 34 per cent of drug-induced deaths [80].

However, the findings of available research on gender differences in treatment entry, completion and outcomes are mixed.

Recent studies, with treatment samples mainly from the United States, but also from the United Kingdom and Germany, have found the following:

(a) *Treatment entry.* Studies of treatment entry have yielded inconsistent results regarding gender differences. In one study of heroin and cocaine users in the United Kingdom [82], male cocaine users were more likely to have contacted a treatment agency than women cocaine users, but no gender differences were found in treatment contact among heroin users. In the United States, two studies found that women who made contact with substance abuse treatment services were less likely to enter treatment than men, but one found no differences in rates of treatment entry [51, 83, 84]. Where differences were found, they were attributed to difficulty in making childcare arrangements, lack of health insurance, an insufficient number of beds for women in residential care and priority being given to pregnant women;

(b) *Treatment completion.* As with treatment entry, studies of treatment completion are also inconsistent [48, 50-52, 54, 71, 83, 85]. Two studies among clients in publicly funded treatment (both residential and non-residential) in the United States found that women had significantly lower completion rates compared with men. In a study by Downey and colleagues, lower completion rates were only found when pregnant women were included in the analysis. In contrast, other studies comparing men and women in various treatment settings in Germany, the United Kingdom and the United States did not find gender differences in treatment completion rates. Among women, factors related to treatment drop-out were mental health problems, severity of substance use problems, and employment problems. In addition, Scott-Lennox and others [86] examined administrative records in one state of the United States, and found that women most likely not to complete treatment were those who were pregnant, were African American, had custody of minor children or were younger than 21 years of age. Swift, Copeland and Hall [66] have identified the following factors that protect against treatment dropout among women: flexible philosophy, friendly staff, few rules, individual counselling, women-only space, home visiting, and childcare;

(c) *Treatment outcome.* Studies in Australia, Germany, the United Kingdom and the United States have generally not found gender differences in treatment outcomes, using data primarily from large national outcome studies [49, 54, 85, 87, 88]. One explanation could be that women who overcome the considerable barriers to treatment entry are more highly motivated to complete treatment;

(d) *Relapse.* Related to lack of gender differences in outcome, some research has found that women relapse less frequently than men. This may be because they attend more treatment sessions than men and have a higher level of motivation [74, 89];

(e) *Women-only treatment.* A meta-analysis of the effectiveness of 33 women's substance abuse treatment programmes [90] and a review by Ashley and others [91] of 38 studies (7 randomized controlled trials and 31 non-randomized studies) found better outcomes for women attending women-only treatment components. Similar results were reported by Trulsson [92] for women receiving substance abuse treatment in Norway. In the latter study, better completion rates were found for women who attended women-only sessions. Another study in Australia [93] found that specialist programmes for women may attract women with different characteristics from those who attend mixed-gender programmes. That study found that the specialist women's programme was significantly more likely to attract women with dependent children, lesbian women, women with a maternal history of drug or alcohol problems and women who had suffered sexual abuse in childhood. These results suggest that gender-sensitive treatment services may be attracting women who might not otherwise have sought treatment for their substance abuse problems. In addition, for lesbian women, women with a history of sexual assault in childhood and those with dependent children, attendance at a specialist women's service reduced the incidence of treatment drop-out.

Key points

The key points covered in chapter 1 are as follows:

(a) There is a lack of research-based information on all aspects of women's substance use and related problems, including physiological and psychosocial effects and consequences, characteristics of women with

substance use problems and their treatment experiences, particularly in terms of information about women in developing countries;

(b) Women are generally less likely than men to use illicit substances such as opioids and cocaine, but more likely to use pharmaceutical substances. However, among young people, there is some evidence of convergence in rates of illicit substance use;

(c) Evidence is emerging from human and animal studies that there are gender differences in the acute effects and longer-term consequences of some illicit substances. For example, women become dependent more quickly on a number of illicit substances, and women who are injecting drug users engage in more HIV risk behaviours and overall have higher mortality rates than men;

(d) Use of illicit substances during pregnancy may result in early delivery and small (for gestational age) babies, as well as other substance-specific effects;

(e) Compared with men, women seeking treatment are more likely to be younger with fewer resources related to education, employment and income, have children living with them and live with a spouse or partner who is using substances;

(f) Women with substance use problems are more likely than men to have experienced trauma and to have higher rates of concurrent psychiatric problems;

(g) Available information generally indicates that women are underrepresented in substance abuse treatment, though information on the extent of substance use problems is limited in many countries;

(h) Some studies on treatment entry and completion have found that women are less likely to enter and complete treatment than men, while others have found no gender differences. There is some evidence that women's family status affects treatment completion;

(i) Research in general has not found gender differences in treatment outcomes. However, recent research has found improved outcomes for women participating in treatment specifically designed to meet their needs. These programmes may attract women who would not otherwise access treatment, such as women with children;

(j) The studies reported above were mainly done in Northern America, Australia and a number of European countries. Studies done in other countries and cultures may produce different results.

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2. Barriers to treatment access

Gender differences described in chapter 1, associated with the use of substances, with available research indicating that, among other differences, women generally have more severe problems at treatment entry and potentially greater obstacles to accessing treatment than men. Despite differences between cultures and countries, women in different regions of the world experience many of the same barriers to accessing and remaining in treatment. These barriers have to do most often with their responsibilities as wives or partners and mothers, the difficulties associated with having a substance-using sexual partner, and the significant additional stigma attached to women's substance use problems. Several studies on perceptions of obstacles or barriers to treatment access by women living in different parts of the world are outlined in box 3.

BOX 3

WOMEN'S PERCEPTIONS OF BARRIERS TO TREATMENT ACCESS

Four studies on the perceptions of substance using women in different regions of the world—Australia, India, Canada and six European countries (Austria, France, Germany, Italy, Portugal and Spain)—about obstacles or barriers to treatment have some consistent themes [1-4]. The themes include family and relationship issues such as fear of losing custody of children or childcare concerns, needing their partner's permission to attend treatment, fear that their partner will leave them; stigma and shame issues such as concern that people will identify them as a drug addict; and treatment issues such as fear of withdrawal from substances, fear of exploitation, not understanding addiction as an illness and thinking they could quit on their own, concern that service providers will not understand their needs as women, concern about lack of services for pregnant women and lack of information about treatment options and waiting times.

It should be noted that although some of the barriers discussed in this chapter may also apply to men, they are generally more significant for women.

While the lack of information about substance use, problems among women in many countries makes it difficult to determine to what extent they are underrepresented in treatment settings, numerous published reports and articles [5-7] on women and substance use have found that women face particular systemic, structural, sociocultural and personal barriers to treatment access that need to be taken into account in the design of services.

Systemic barriers

Systemic barriers are those barriers that impede the development of services that respond to women's needs. Some of these barriers are not specific to the development of substance use treatment services but may also be true for other health-related services, such as HIV-risk reduction programmes or heart-health programmes. Significant systemic barriers for women include:

(a) *Lack of decision-making power.* Women are underrepresented in positions of power that can influence policy development and resource allocation. At the highest level, the United Nations Development Fund for Women [8] reports that women are largely absent from parliaments, constituting only approximately 14 per cent of members on average, with no systematic differences between rich and poor countries. This may make it more difficult to make the relevant bodies aware of the need for research and developing policies that address gender issues and for resource allocation directed to women's substance abuse treatment;

(b) *Limited awareness of gender differences in factors that determine health status and outcome.* Many factors other than access to traditional health services influence individual health status. Biology, education, income, housing, employment, personal health practices and the physical environment can contribute to differences in health status between individuals. There are also gender differences in many of these factors that need to be taken into account in designing health services, including substance abuse services. For example, women generally have lower incomes, which can affect their ability to maintain good health or pay for needed health services. Interventions to change high-risk behaviour, such as sharing injecting equipment or using condoms, need to be gender-specific because women often have less power to negotiate safer practices than men. Especially in developing countries, substance use problems may be made worse by factors such as poor nutrition, poverty, poor reproductive health and literacy problems;

(c) *Lack of knowledge of women with substance use problems and their treatment needs relevant to different sociocultural and political circumstances.* There has been an increase in the number of published and unpublished articles and reports on women with substance use problems, yet gender issues are not systematically addressed in population surveys, other epidemiological studies of substance use or in biological, prevention and treatment research studies—both pharmacological and behavioural. Available information is also heavily weighted towards women in developed regions of the world, such as North America, Europe and Australia. Much less is known about women in Africa, Asia and South America. But both in the developed and developing regions of the world, information required for planning and implementing services for women may not be available;

(d) *Lack of appropriate gender-responsive and low-cost, evidence-based treatment models.* Though principles, guidelines, best practices and effective models of women's substance abuse treatment have been published over the last several decades, the majority of services are still designed primarily for men. In addition, many of the women-specific treatment approaches and models have been developed in the United States or other developed countries and would require resources to research their application for women living in different political and sociocultural contexts;

(e) *Differences in the organization and funding of health services.* Differences in the way that health services and substance abuse treatment services are organized and funded can affect the adaptability of evidence-based treatment models for women. For example, though low-cost or free outpatient services located close to where women live may be more accessible than residential services that

charge a fee, countries differ in the acceptability and availability of outpatient versus residential treatment services and whether there is a cost for treatment;

(f) *Need for a comprehensive array of services.* Compared with men, women seeking treatment generally have more severe problems, including the experience of trauma and mental health problems, greater family responsibilities and fewer resources in terms of education, employment and income. They may require prenatal services, child-welfare services and trauma and mental health services, as well as attention to practical needs for childcare, transportation, food and housing. Because it may not be feasible to provide all these services at one site, models for collaboration, partnering and service agreements need to be researched and developed. This may be particularly challenging in areas with few resources and/or with a small population base; where these services may not exist; or if women have to travel to receive such services.

Structural barriers

Structural barriers are policies and practices at the service or programme level that make it difficult for women to access substance abuse treatment. As with systemic barriers, they may apply not just to substance abuse services, but also to other types of health services, and not just to women, but also to men.

(a) *Childcare.* The studies discussed in the previous chapter indicate that women seeking treatment are more likely than men to be living with dependent children. Lack of childcare is probably the most consistent factor restricting women's treatment access identified in the literature and the case studies included in this publication. Studies discussed in the previous chapter indicate that women are more likely than men to be living with a substance using partner, have families of origin with substance use problems and have experienced childhood physical or sexual abuse or neglect. This may make these "natural" sources of childcare and support (e.g. spouses, parents or other family members) unavailable to women. And although society is rightly concerned about the welfare of children, few substance abuse treatment programmes are funded to provide childcare or programming for children;

(b) *Services for pregnant women.* Pregnant women face problems not faced by men. In some countries, substance use during pregnancy can result in criminal charges and imprisonment for the duration of the pregnancy and lactation. In other jurisdictions, child welfare authorities may equate substance use problems with

abuse or neglect. An unintended consequence of this policy is that women who have substance use problems may be less likely to seek prenatal care in the course of their pregnancy, with serious health consequences to the mother, foetus and society. Clinical experience also indicates that women who lose custody of their children may become pregnant again. This can result in a cycle of further pregnancies each time a woman loses custody of her child. Even without such punitive approaches, effective services (e.g. that include prenatal care, targeted substance abuse treatment and other needed health and social services) may not be available for pregnant women, or they may not be given priority admission to substance abuse treatment services;

(c) *Location and cost of treatment programmes.* Factors such as cultural norms that do not permit women to leave their communities, women's childcare and household responsibilities, lack of transportation to get to treatment and the costs associated with treatment make it difficult for many women to leave their communities to attend residential treatment. Women may also experience problems in accessing outpatient programmes that are some distance from where they live even if they are located in the same city or community;

(d) *Rigid programme schedules.* Women's family and household responsibilities can make it difficult for them to attend programmes with fixed schedules. Flexible programme scheduling with options for day/weekend/evening can improve access. Research [9] indicates that women who receive opioid maintenance treatment that requires daily clinic attendance experience particular barriers related to limited programme hours (e.g. not open evenings), as well as rules regarding take-away doses. Many programmes are in fixed locations and do not provide outreach;

(e) *Waiting list and immediate response capacity.* Some studies (see chapter 1) have shown that women may have to wait longer than men to enter treatment, particularly residential treatment. The inability to provide an immediate response or support to women following initial contact can result in women being lost to treatment;

(f) *Denial of admission to women using psychoactive medication.* Some programmes do not admit clients using medication to treat concurrent psychiatric disorders. This may have a greater impact on women than men because women have higher rates of some psychiatric disorders such as anxiety, depression and post-traumatic stress disorder and greater rates of use of psychoactive medication. Similarly, some programmes do not admit clients who are on methadone or other opioid substitution drugs because of the requirement

that they abstain from all substances. This may have particular implications for women who are pregnant and dependent on opioids;

(g) *Physical safety.* For all women, but particularly for those who have experienced physical or sexual abuse or whose current lives are extremely vulnerable to violence (e.g. women engaged in sex work), lack of physical safety inside and outside the treatment programme setting can be a barrier to entering and remaining in treatment. Safety issues can range from men being able to access women's sleeping areas in residential treatment to services being located in unsafe areas;

(h) *Harm reduction programming.* Some women are not ready to pursue abstinence treatment goals or may not see reducing their substance use as a priority. If harm reduction programme options are not available, women may not be engaged or retained in treatment;

(i) *Service coordination.* People who have substance use problems often require a variety of health and social services. Poor coordination and linkages between key systems can present serious obstacles to being able to address their needs. For women, coordination and linkages are particularly crucial between the substance abuse treatment system, the child welfare system and the prenatal-care system. Barriers to coordination between systems often involve differences in the understanding of substance use problems, territoriality (who owns the client) and different policies and procedures regarding confidentiality;

(j) *Lack of identification, referral and intervention in primary care and other sectors.* Studies and reports indicate the important role that helping professionals can play in identifying substance use problems among their clients and supporting them to access substance abuse treatment. However, these professionals may be poorly trained for these tasks. Helping professionals may also reflect the norms of the culture or community in which they live. They may not acknowledge that women use substances, hold negative attitudes about women with substance use problems or have little awareness and understanding of factors that may put women at risk of substance use problems, including biological differences, physical and sexual abuse, substance-using partners and anxiety and depression. This is of particular concern, given that women themselves may not see their problems as related to their substance use but may seek help for physical or mental health problems or be more comfortable receiving help in non-substance abuse treatment settings because of stigma issues;

(k) *Information on treatment options.* Helping professionals, as well as women and their families, often do not have information on available treatment options.

Social, cultural and personal barriers

Women experience significant social, cultural and personal barriers when accessing substance abuse treatment. This is related to the social and cultural norms that exist, which include the role that a woman has and what type of behaviour is considered appropriate; women's lack of empowerment in many societies; as well as societal and community norms and attitudes about women who have substance use problems.

Disadvantaged life circumstances. In some countries, particularly in the developing world, women may be living in very disadvantaged circumstances characterized by poverty, lack of basic health care and reproductive care, low literacy rates, lack of access to household money and domestic violence. In some societies, women may have little power or resources to change their life circumstances.

Stigma, shame and guilt. In most societies and cultures women's substance use is more stigmatized than men's. As a result, the shame and guilt that women experience about their substance use and their "failure" to live up to society's roles and expectations make it difficult for women to acknowledge their substance use and seek help. These feelings may be even greater for women engaged in sex work, for women who have children that they cannot care for properly and for women living in societies with very strong cultural taboos against women using substances. In these circumstances, women may perceive themselves as deviating even further from societal expectations.

Fear of losing custody of children. Women who are pregnant or parenting are often fearful of disclosing that they have a substance use problem and seeking treatment. They have an often well-founded fear that they will be deemed an unfit mother and lose custody of their children. This concern is evident in many of the case studies described in this publication.

Lack of support from family, particularly husband/partner/significant male. Studies have documented that women are more likely than men to have a substance-using sexual partner and to have families of origin who have substance use problems. Because relationships play such a significant role in women's lives, women living with a substance-using partner may be deterred from seeking treatment because they fear the loss of the relationship. In some cultures, women may be forbidden to

leave their homes to go to treatment, or husbands may not support their wives leaving family and household responsibilities. In these circumstances, family members may only bring women to treatment when they are unable to fulfil their family responsibilities or are very sick.

Substance use as a solution rather than a problem. For many women, substances are a way of self-medicating emotional problems or the experience of living in conditions of extreme distress. For example, some women are in relationships that are characterized by shared substance use, physical and sexual abuse, HIV and other infectious diseases and, sometimes, coercion into sex work or the illicit drug trade. In such situations, women may feel overwhelmed by their life circumstances and unable to see a way out.

Lack of confidence in the effectiveness of treatment. Research on women's perceptions of treatment indicates that some women feel that they can handle the problems themselves and/or lack confidence in the effectiveness of treatment.

Key points

The key points covered in chapter 2 are as follows:

- There are systemic barriers to women accessing treatment that reflect a lack of awareness and understanding of gender differences and a limited ability for women to influence policy and resource-allocation decisions in many countries. Systemic barriers impede the development of services responsive to women's needs.
- Policies and practices at the service or programme level present structural barriers to women accessing treatment. Particularly critical barriers for women are lack of childcare resources, punitive approaches to pregnant women using substances, programme location and cost, rigid programme schedules and admission criteria, safety concerns and lack of knowledge about available treatment options.
- Women also experience social, cultural and personal barriers to treatment entry. These include the significant stigma and shame and guilt associated with substance use and related problems among women, fear of losing custody of children, lack of partner and other family support to go to treatment and lack of confidence about treatment.

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3. Promoting gender-responsive services

There is now more knowledge and awareness that gender differences in substance use and related problems require different treatment approaches. Promotion of gender issues at the international, regional or national level gives official recognition to this knowledge. Chapter 3 illustrates how public institutions, particularly government institutions, can promote attention to gender in policy development, resource allocation and the development and implementation of treatment best practices, standards or guidelines.

At the international level, Member States of the United Nations have developed a consensus on treatment strategy development that specifically includes references to gender, as illustrated in box 4.

In addition to the United Nations and its various agencies, other international organizations and transnational networks have addressed issues related to women's use of substances, such as the World Health Organization, Inter-American Drug Abuse Control Commission, International Council on Alcohol and Addictions and the International Harm Reduction Association. An overview of this work is included in the report by Hedrich [1]. In Europe, the Pompidou Group initiated work on women and substance use in 1984. That resulted in a series of symposiums and reports on the topic (see the references below).

At the national level, some countries have identified women as a special population in their national drug strategies or in policy development, designated specific resources for women's treatment or identified women in substance abuse best-practice recommendations, care standards or guidelines. For example, in the United States, Public Law 94-371, passed in 1975, mandated the development of specialized treatment for women [2]. Subsequently, a 1990 report by the United States Institute of Medicine identified the unsatisfactory state of knowledge about women with

substance use problems and recommended that a special initiative be undertaken on the treatment of drug abuse and dependence among pregnant women and women with young children [3, 4]. United States national agencies, such as the National Institute on Drug Abuse and the United States Center for Substance Abuse Treatment, have supported gender-based research and programme development for women.

In Canada, women were identified as a population at risk under the national drug strategy, resulting in a series of activities such as studies, consultations with partners and key stakeholders, round tables and national workshops, policy analysis and, most recently, the development of best-practice guidelines [5, 6]. The federal department of health also provides funding to provinces and territories to increase access to treatment and rehabilitation services, in particular for services to women and youth [7]. The process for the development of best practices is described in box 5.

The Australian National Drug Strategy Framework refers to the development of services for specific population groups including women with children [8]. The Australian National Minimum Data Set of Clients of Alcohol and Other Drug Treatment Services monitors and reports on the patterns of service utilization among women annually.

In the United Kingdom, services for women are addressed in a number of government publications, including *Models of Care for the Treatment of Drug Misusers* [9] and *Commissioning Standards: Drug and Alcohol Treatment and Care* [10]. These are only some examples, and there may well be others in other regions of the world.

Another example is provided by Germany, whose Action Plan on Drugs and Addiction specifically addresses gender, as illustrated in box 6 below.

BOX 4

TWENTIETH SPECIAL SESSION OF THE GENERAL ASSEMBLY, DEVOTED TO COUNTERING THE WORLD DRUG PROBLEM TOGETHER, 8-10 JUNE 1998

The Political Declaration (General Assembly resolution S-20/2, annex) and the Declaration on the Guiding Principles of Drug Demand Reduction (Assembly resolution S-20/3, annex) include several statements that are relevant to the development of women's drug treatment services. In the Political Declaration adopted by the Assembly at its twentieth special session, Member States of the United Nations:

"Undertake to ensure that women and men both benefit equally, and without any discrimination, from strategies directed against the world drug problem, through their involvement in all stages of programmes and policy-making;

" ...

"Affirm our determination to provide the necessary resources for treatment and rehabilitation and to enable social reintegration to restore dignity and hope to children, youth, women and men who have become drug abusers and to fight against all aspects of the world drug problem;

" ...

"Recognize that demand reduction is an indispensable pillar in the global approach to countering the world drug problem, commit ourselves to introducing into our national programmes and strategies the provisions set out in the Declaration on the Guiding Principles of Drug Demand Reduction, to working closely with the United Nations International Drug Control Programme to develop action-oriented strategies to assist in the implementation of the Declaration, and to establishing the year 2003 as a target date for new or enhanced drug demand reduction strategies and programmes set up in close collaboration with public health, social welfare and law enforcement authorities, and also commit ourselves to achieving significant and measurable results in the field of demand reduction by the year 2008."

In paragraph 8 of the Declaration on the Guiding Principles of Drug Demand Reduction, it is stated that:

" ... "

"(b) Demand reduction policies shall:

- "(i) Aim at preventing the use of drugs and at reducing the adverse consequences of drug abuse;*
- "(ii) Provide for and encourage active and coordinated participation of individuals at the community level, both generally and in situations of particular risk, by virtue, for example, of their geographical location, economic conditions or relatively large addict populations;*
- "(iii) Be sensitive to both culture and gender;*
- "(iv) Contribute towards developing and sustaining environments."*

BOX 5

BEST PRACTICES FOR THE TREATMENT OF WOMEN WITH SUBSTANCE USE PROBLEMS IN CANADA

In 1998, the Federal/Provincial/Territorial Committee on Alcohol and Other Drug Issues developed a research agenda to address the identification of best practices and the evaluation of innovative treatment approaches in Canada. To oversee the implementation of this research agenda, the Committee established the Working Group on the Accountability and Evaluation Framework and Research Agenda (ADTR Working Group) with representatives from the provinces and territories (government ministries and addiction commissions), Health Canada and other federal government departments concerned with substance abuse treatment and rehabilitation issues. The research agenda has resulted in a series of Health Canada publications on best practices in substance use treatment and rehabilitation for different population groups including women.

The overall goal of the women's best-practice project was to make available across Canada current information on best practices in the treatment and rehabilitation of women with substance use problems with the objective of defining evidence-based best practices and key components and supports in providing treatment and rehabilitation programmes for women.

Development of the report involved telephone interviews with key experts, primarily from Canada but also from the United States of America. Key experts were asked to provide their expert opinion on the following areas: the needs of women and service access barriers; best practice protocols, principal approaches and practices for client outreach, contact and engagement; client retention; treatment values and philosophy; treatment approaches; relapse prevention; structure of treatment; and integration of additional support services. For each area, a focused literature search was also undertaken. The Working Group acted as an advisory committee to the project and reviewed the various drafts of the report.

The report was distributed to substance abuse treatment agencies across Canada and also put on the web. It can be found at the following web site: www.cds-sca.com. Following the release of the best practice report in 2001, a national workshop was held in June 2002 involving 40 professionals from across Canada working with women with substance use problems. The objectives of the workshop were: to disseminate best practice knowledge based on the publication *Best Practices: Treatment and Rehabilitation for Women with Substance Use Problems* [6]; to network and exchange information on issues pertaining to best practices; and to identify how best to apply best practices to treatment and rehabilitation services for women within their respective provinces/territories.

There are two examples of how the information has been used at the system level and at the programme level. In the Province of Ontario, a Women's Service Strategy Group was convened by the Ministry of Health and Long-Term Care (which funds substance abuse treatment services in Ontario) with the goal of advancing best practice in women's addiction services. The objectives of this Group were: to make best practices for women's substance abuse treatment more specific, more accessible and operational; to develop standards for women's services; and to develop a programme evaluation tool for measuring the best practices status of programmes that serve women. Members of the working group met over a period of approximately nine months in 2002-2003 and developed a document that included contextual information (provincial policy, the Ontario substance abuse treatment system, a profile of women with substance use problems and Health Canada's best practice guidelines); best practice standards and how they could be applied; and a best practices evaluation tool. The draft document is currently being reviewed by regional staff from the Ministry and practitioners in the field, and will be finalized in 2004. The intent is that the best practice evaluation tool would be used by both staff from the Ministry of Health and Long-Term Care and individual treatment services to review programming for women clients in terms of use of best practices and identify where improvements may need to be made.

In the Province of Manitoba, River House, a women-only programme administered by the Addictions Foundation of Manitoba, has been implementing many of the best practices. These include:

- The house is located in an upscale area of Winnipeg, with nothing designating River House as a treatment centre.
- The house is decorated tastefully, with restful colours.
- The programme conducts information sessions in the afternoons where women can come and receive information, and also see the house, which reduces anxiety. Assessment and intake are in the same area, so if a woman wishes to consider engaging in formal programming, she does not have to return for another appointment.
- The programme collaborates with adjunct agencies to reduce stigmatization, and to lobby for resources and childcare if this is an issue for women.
- River House works very closely with the medical community to provide care for pregnant women.
- Programming approaches are flexible to meet the needs of women.
- The programme includes information and skill development in reducing stress, increasing self-esteem and avoiding family violence, as well as information on the effects of alcohol and other drugs.
- To address women's health issues, a female physician is available on site to programme clients as well as to women coming to the information sessions who do not want to participate in a formal programme. The Winnipeg Regional Authority health nurse comes to discuss general health concerns with the women.
- Women are connected to resources and supports when leaving treatment. The programme tries as much as possible to address adjunct concerns while women are in treatment, so they are already connected to the resources they may need in their recovery. There is also the "alumni", who continue to drop in and offer support.
- A continuing care programme provides follow-up for up to two years following treatment.

BOX 6**ACTION PLAN ON DRUGS AND ADDICTION**

In Germany, women's needs have been recognized in the country's Action Plan on Drugs and Addiction [11], which makes specific reference to women in a number of Action Plan objectives, including implementing gender-mainstreaming in drugs policy; promoting early recognition and early intervention in the event of improper use of medication (largely among women) and taking more account of experience with violence in connection with addiction (of women). In addition, a German expert panel on drug-dependent women and gender mainstreaming has been formed. It plans to develop an overview of women-only facilities in Germany, as well as an overview of all services that have developed gender-sensitive programming; initiate a study evaluating gender sensitivity in substance abuse treatment institutions and programmes in terms of the staffing and programme content; and provide information on lessons learned in 20 years of women's substance abuse treatment in Germany, including examples and unmet needs. Some of the lessons learned in the course of this project include: not allowing women's issues to be identified with other discriminated minorities, using gender mainstreaming to engage as many people as possible in discussions of the issues, and encouraging effectiveness and efficacy studies on women's drug treatment [12].

Case studies

The case studies that follow illustrate a variety of strategies for promoting gender-responsive services for women in different regions and countries. The first describes the work of the Regional Office for South Asia of the United Nations Office on Drugs and Crime, which has engaged in a range of approaches and activities to promote gender-responsive services for women across the region.

Following South Asia are four case studies: one from Chile, two from Switzerland and a transnational project in the European Union. These all illustrate the development of standards/guidelines and their practical implementations for gender-responsive services. Such guidelines are necessary in order to define what gender-responsive services are, so that already existing non-gender-specific services can be adjusted accordingly. These practices/guidelines are developed through having had considerable experience in providing treatment to women, as was illustrated above in descriptions of the work in Canada (box 5) and Germany (box 6).

Of the two case studies from Switzerland, the first describes the best practice guidelines and the second, Quai 9, shows the guidelines being put into practice.

The final case study in this chapter is from South Africa. It describes a women-focused HIV prevention intervention designed initially for African-American women crack users. This programme was piloted in South Africa as an intervention for Black South African sex workers who use cocaine and is an example of one of the systemic barriers that gender-responsive services face and the extent to which low-cost, effective treatment

interventions developed in one country can be adapted to another culture and country.

South Asia: Increased awareness about gender issues

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Background

In the 1990s, use of opiates, especially heroin, increased among women substance users in different cities in India. The majority of female substance users were single, educated and employed, and they had started using substances quite early. Women substance users are also known to start having sexual relations at a younger age and to share injecting equipment. Those who come from non-marginalized groups are often unaware of treatment options and have not sought them. Some treatment programmes cater to women with strong religious beliefs or spiritual inclinations, taking these into account during the treatment process.

Approach

The Regional Office for South Asia of the United Nations Office on Drugs and Crime has recognized that no single strategy can cope with the ever-changing drug scene or the regional and cultural differences in the South Asian region. It has thus adopted a plan that encourages Governments in the region to develop

effective strategies and appropriate responses to deal with the local and regional situation.

There is a general lack of knowledge regarding the female-oriented treatment of substance use. Among the areas that still need to be examined are: the gender issue and how it relates to substance abuse and HIV; developing strategies that discourage substance abuse; promoting rehabilitation and recovery; and supporting appropriate, affordable and quality health-care and related services for women in all stages of life.

In addition, attention needs to be given to training modules and specialist training to reduce drug use, encouraging Governments to improve access to appropriate treatment and rehabilitative services for affected women, supporting programmes that address HIV risk prevention for partners of substance users, also for women substance users engaged in high-risk sexual behaviour, and increasing the participation of women in demand reduction programmes.

More general issues regarding the approach to better understanding the environment in which women substance users live are: highlighting situational factors, such as violence, that increase the burden on women; building up support groups, including peer-led networks and interventions; and strengthening mechanisms to rebuild family relationships that have become strained because of substance abuse.

Activities

The Regional Office for South Asia of the United Nations Office on Drugs and Crime has undertaken a number of activities to support these strategies by using the media and other bodies. For example, a guidebook has been prepared on prevention activities within the community to be used by women's groups, service providers, non-governmental organizations, policy makers and the general public. In addition, a monograph entitled *Women and Drug Abuse: The Problem in India* has been published; the monograph highlights issues for women with substance use problems and women living with family members with substance use problems. Also, the Regional Office supports pilot interventions by various non-governmental organizations aimed at preventing risk and vulnerability among women substance users or women living with a family member's substance use.

Training programmes have been organized in various regions of the country and are designed to reach out and empower women to reduce risks related to substance use and HIV, for both women with substance use problems

and family members with similar problems. As well, epidemiological studies of women's substance use are being carried out.

Demand reduction work in the north-eastern states of India focuses on women who are outcast because of their substance use, involved in sex work and are often HIV-positive. This work has resulted in funding for a treatment and rehabilitation centre and the employment of peer educators who conduct gender sensitization programmes to raise awareness among the "significant other" population. Many of the peer educators themselves are HIV-positive, recovering injecting drug users, and are also affected by their partner's substance use. Peer educators have also started self-help groups and projects that generate income, such as selling fast food, weaving and making clothes.

Coordinated HIV/AIDS Response through Capacity-building and Awareness (CHARCA) is a partnership between the Government, non-governmental organizations, donors and United Nations agencies that works on reducing the vulnerability of young women to HIV and sexually transmitted infections by providing information, improving skills and increasing access to quality reproductive health services.

Another project—"Prevention of transmission of HIV among substance users in the South Asian Association for Regional Cooperation (SAARC) countries"—is making key stakeholders aware of the gender dimensions of the problem. It ensures that women substance users have better access, availability and acceptability of services related to HIV prevention. It includes issues of gender and sexuality in a project related to substance abuse and HIV/AIDS among young people.

Results/accomplishments

It has become possible to mainstream gender concerns in the ongoing demand reduction programmes in the region, and also for service providers to negotiate within their own programmes to address the special concerns of both women substance users and women who are partners of substance users. Although the responses are in the early stages, the future programmes of the Regional Office for South Asia will continue to reinforce the strategy that has been adopted.

Challenges

There is a lack of accurate epidemiological data on the prevalence of substance use among women, which makes it difficult to convince stakeholders of the need to address this problem.

Another problem is that, although some countries in the region have clearly defined strategic plans for drug demand reduction and HIV/AIDS prevention, these strategies are not necessarily gender-sensitive. This is particularly critical for areas that have increasing rates of HIV as a result of substance use, and care and support for women need to be adequately addressed.

Comprehensive programmes that address the special needs of women substance users have low priority, and resource allocations are consequently inadequate. Also, the costs and models for special programmes for women substance users need to be reviewed.

Finally, women's groups in the region need to be further trained to address concerns related to substance use. This also includes general education in departments dealing with women and child development to encourage the incorporation of specific processes into these programmes. Service providers engaged in delivering national programmes for women's empowerment could also strengthen intersectoral collaboration by developing ready-to-use toolkits.

Lessons learned

A great deal still needs to be done in the South Asia region: HIV and sexually transmitted disease (STD) counselling and testing facilities are needed; sensitization and training on gender issues related to substance use for professionals, police and service providers are necessary; and services for pregnant women in the community, with adequately trained and sensitive staff to recognize additional substance use problems need to be implemented, to mention just a few. However, since the project has been running, programmes with a community focus have become more accessible and less stigmatizing.

Best practices and guidelines for gender-responsive treatment

Chile: Developing technical guidelines

Name: Technical guidelines for the incorporation of a gender approach in projects for the treatment and rehabilitation of people with drug problems.

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Background

Although use of illicit substances and alcohol is higher among men in all age groups and populations studied in Chile, the rates of cocaine dependency and cocaine base paste are higher among Chilean women. Based on results from the 2002 national prevalence survey, marijuana use has stabilized among 12- to 18-year-olds. Among women, there has been a change in patterns of substance use from solitary, to group, to street use; and among older women, use of pharmaceutical substances is associated with emotional disorders. As in other countries, women with substance use problems are more likely than men to have family responsibilities and experience greater stigma as a result of their substance use.

Currently in Chile, most treatment programmes do not offer specific services to women. Some recognize that their services have difficulty in attracting and retaining women in treatment and that they are not designed to provide gender-responsive services; others do not recognize the gender issue at all. Staff are often unqualified, and there is an absence of a complete continuum of care, from outreach to residential treatment for people with different types of substance use problems. At the client level, women encounter barriers in accessing treatment because of childcare and household responsibilities, as well as the lack of family support and social networks.

Objectives

To develop a national policy that includes gender awareness in treatment services for women with substance use problems; to establish strategies for discussion and analysis of gender issues and their relationship to the use of substances; to contribute to the process of identifying risk factors for substance use among Chilean women; to propose treatment guidelines for women, including methods for identification and treatment referral and access, and employing qualified professionals and other staff to treat women.

Activities

In 2002, representatives from the National Service for Women, Ministry of Justice (in charge of prison services), Ministry of Health and clinical experts from public and private institutions providing treatment for women met at the invitation of the Consejo Nacional para el Control de Estupefacientes. The purpose of the meeting was to form a working group to draft treatment guidelines for women. The group was asked to discuss

the following questions about the project: How should gender be included in prevalence and other types of studies? How can treatment programmes be made more accessible to women? How to identify women earlier in primary-care or prenatal-care settings? How to increase the capacity of services for women—whether by developing separate services for women, or by including a gender approach in all treatment services?

Other issues were discussed, such as the need for multi-sectoral coordination between health, education and shelters in order to prevent women from dropping out of treatment, especially women with children; improving the knowledge and skills of counsellors regarding gender issues; and the incorporation of a gender approach in treatment programmes.

Guidelines for treatment were divided into three chapters: theoretical framework; therapeutic interventions for women; and (treatment) teamwork.

These chapters addressed issues such as:

- Maintaining a comprehensive rather than a confrontational approach, especially at the beginning of the therapeutic process;
- Maintaining privacy when treating traumatic experiences linked to abuse and maltreatment;
- Focusing on women's relationships (family and other relatives) to restore social networks;
- Providing more focus on individual treatment for women (in comparison with men);
- Allowing a longer time for treatment in order to establish linkage and therapeutic bonding.

The working group met monthly over a 12-month period to draft the guidelines, which were distributed in 2003 for review and comment, in particular from the Executive Secretariat and the regional offices of CONACE and the Ministry of Health.

Following this first phase, a seminar will be held in 2004 to generate further discussion and feedback on the draft guidelines and, following final revisions to the document, it will then become official law.

Results/accomplishments

This project is still in the developmental stage. Once the guidelines have been finalized and incorporated into the law, it will be possible to follow up and evaluate treatment centres that implement the guidelines.

Challenges

Two of the immediate challenges are overcoming the attitude that women do not require different treatment and educating those in treatment service leadership positions about the need for a gender-responsive approach in programmes that serve women. Also, it is necessary to address gender in all treatment plans, facilitate access to treatment, improve treatment engagement and effectiveness and encourage the discussion of gender issues among treatment teams.

Lessons learned

In order for this project to be a success, it is important to create alliances with governmental and non-governmental organizations, both in Chile and in other countries where the issue is being addressed.

Switzerland: Guidelines for low-threshold services for women

Name: Women centred! Requirements for low-threshold drug services: a toolkit for practice
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Government, ongoing funding

Background

Research in Switzerland has demonstrated differences between men and women with substance use problems, including patterns of use, the reasons why substance use problems develop and their treatment needs and experiences. However, clinical experience and empirical studies have shown that women who use substances are under-represented in treatment facilities, and a scientific publication commissioned by the Swiss Federal Office of Public Health (SFOPH)—*Women Addiction Perspective*, which was published in 1995—did not help to increase service responses to women in project proposals submitted to SFOPH, as was hoped. At that time, services were not being pressured by sponsors to be responsive to women or gender, and institutions received funding even when their services were not gender-responsive. Often the heads of the institutions, especially those of mixed gender, were usually men and there was only a little, sporadic networking among interested female professionals, with many women working alone. Treatment approaches were also heavily based on ideology rather than evidence.

Consequently, SFOPH had a mandate in 1997 to promote and support services responsive to women and gender with the following objectives:

1. To provide and continuously develop scientific principles and instruments for realizing services relating to addiction and prevention;
2. To establish criteria for concepts and activities;
3. To implement quality criteria responsive to women in (treatment) institutions;
4. To provide information at international conferences about the development of addiction services.

The aim was to cover all aspects of addiction services, with the “clients” being specialists, institutions, authorities and members of the trade press involved in addiction and professionals working in the field in Switzerland and abroad. This case study addresses one aspect of this broader mandate and describes the development of quality guidelines for low-threshold services.

SFOPH was approached about the quality of low-threshold services, where women dependent on substances were particularly poorly represented. That was due to several factors: the structure of the facilities was in some cases unmanageable due to their size; they were oriented towards the needs of men (no separate sanitary facilities for women in emergency shelters, inadequate or no provision for drug-dependent mothers and their children); women clients were ashamed to admit that they had a substance use problem; and if they had children, they were afraid of losing custody of them. As a result, SFOPH formed a multidisciplinary group to look at the issue. SFOPH officially commissioned the group to pursue this work and funded the project.

Objectives

To develop a list of requirements for services responsive to women and practical criteria for low-threshold services.

Activities

A core group of five female professionals (including an officer from SFOPH) was established. This core group prepared the individual steps in the development process. The outcome of each step was presented for discussion to a support group of 12 other women working in treatment settings. This approach ensured broad support for the project from all areas of low-threshold services (contact points and open-access centres, emergency shelters, employment projects, outreach workers, heroin maintenance projects). Also, emphasis was put on

ensuring that the interests of those working in both gender-specific and mixed-gender programmes were taken into account.

Step 1: A brainstorming session was held to gain an overview of all the activities and tasks being pursued and performed in the services represented in the project. The review of the current situation provided a large amount of raw information that was subsequently organized using the following criteria: What services are being offered? What is the intended effect of these services? Which target groups-apart from the clients-are involved? What services were being offered to achieve which objectives had to be taken into account with this approach.

Step 2: The aim was to identify the objectives and services that were necessary for a programme that was responsive to women. One of the things that became clear was that it was largely superfluous to distinguish between the various types of programmes (residential, employment, day services) and therefore unnecessary to retain this distinction. The material was then analysed in terms of three categories: structure, process and outcome. This categorization produced five overriding objectives, which were felt to be relevant for low-threshold services responsive to women.

Step 3: This step involved assigning the services and their requirements in terms of structures, process and outcome to the five objectives, which need to be pursued in client-based work. These are as follows:

1. Promoting health awareness among clients.
2. Increasing awareness in the community of client-specific needs.
3. Supporting clients in taking steps to escape from the role of victim.
4. Empowering and supporting clients in their efforts to establish or re-establish a small supportive network.
5. Enabling clients to develop perspectives for an occupation and employment.

For each objective, a list of services required to meet that objective was developed. For example, under “Promoting health awareness among clients”, the checklist of services included:

- A special room provided exclusively for women;
- Provision of shelter beds;
- Regular visits from a gynaecologist;
- Easy access to women-specific information;

- AIDS and hepatitis prevention discussed with each client;
- Opiate or substitution programmes with separate injection room and sanitary facilities for each gender and childcare;
- Dispensing of syringes, condoms and sanitary protection;
- Separate showering and washing facilities;
- Clients accompanied to medical health services;
- Advice and/or triage on women's health issues.

For each of these services, the guidelines lay out the required structure, process and outcome results. "Regular visits from a gynaecologist" provides an example:

- Service: a gynaecologist is present for two hours twice a month;
- Structure: an examination room is available; the doctor's costs are covered as far as possible by health insurance and the overall service delivery plan includes a statement that clients have access to basic gynaecological services;
- Process: staff inform clients within one month about the new service; staff motivate and support clients to use the new service; staff systematically survey all clients regarding their impressions of the new service, and the results are recorded in writing; after six months, staff discuss client feedback with the doctor and the results of the discussion are incorporated into service delivery;
- Result: within 12 months the service is used at least once by 60 per cent of the clients; infections among clients drop by 30 per cent within one year; 40 per cent of clients register with a gynaecological practice within one year.

The quality development toolkit was published in French and German in 2000 and in English in 2004. In a further two-year (2001-2003) project, 10 institutions used the toolkit, which is entitled *Women Centred! Requirements for Low-threshold Drugs Services: a Toolkit for Practice*.

Results/accomplishments

SFOPH's overall mandate

Professionals have become more aware of the need for addiction services that are responsive to women and there is a growing realization that gender criteria are required in order to deliver quality services. Thus, gender

criteria are increasingly being applied in sponsors' evaluation practices and programming features specific to women's needs are more often included in the approach and measures adopted by addiction services.

The above-mentioned results have been measured by regular reports on the work achieved within the framework of the mandate (self-evaluation), by surveying the institutions involved to determine whether the services responsive to women's needs are being used and, finally, by the increase in the number of publications dealing with women and gender-specific aspects of addiction work in Switzerland.

Related to the project on low-threshold services

The project to develop women-responsive guidelines for low-threshold services has official backing from SFOPH. *Women Centred! Requirements for Low-threshold Drug Services: a Toolkit for Practice* has translated scientific findings into a form that allows for their practical application in service settings. Ten institutions are involved in implementing the guidelines and have made a two-year commitment to participate in the project. Promoting realistic and achievable objectives with respect to substance abuse services responsive to women increases credibility. Highly motivated and dedicated female professionals have become involved. Training in the fields of project management, evaluation methods and sustainability have been provided and found useful.

Challenges

Challenges include changes to personnel; poor knowledge of project management and self-evaluation in the institutions; and lack of self-confidence among women professionals in submitting demands to their institutions and obtaining acceptance for them.

Lesson learned

It is important to have a contact centre for questions and projects relating to addiction services that are responsive to women's needs. Continuity is essential in the activities of the SFOPH and/or the mandate regarding the promotion of addiction services responsive to women; knowledge transfer, training and networking among professionals have all helped to overcome prejudice and encourage a readiness to provide addiction services responsive to women's needs; the provision of practical instruments to identify specific opportunities for addiction services responsive to women's needs has contributed to the success of the project.

Switzerland: Implementing guidelines into “A Moment for Women” at Quai 9

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Non-governmental organization. Years of operation: 3

This low-threshold service is an example of how guidelines can be incorporated into the programme. “A Moment for Women” provides a designated meeting time for women in the context of a mixed-gender service.

Background

Quai 9 is a low-threshold drop-in centre with injecting facilities. Over a period of about 10 years, staff from an outreach bus service in Geneva discussed the need for gender-responsive services for women. In addition, the outreach service participated in a study on women with substance dependencies. In 2000, a specific mandate to contact women was implemented. Quai 9 itself was started in 2001, and in 2002 specific services for women were initiated. These included the distribution of a prevention kit specifically designed for women.

Objectives

The objectives are to reduce circumstances experienced by women that make them vulnerable; to limit the exchange of unprotected sexual services; to improve gynaecological follow-up; and to reduce conjugal violence and other aggressive behaviours.

Activities

Programme: “A Moment for Women” offers a designated time for women every Wednesday from noon to 2 p.m. The staff consists only of women from the various harm reduction services in the Groupe sida Genève. On average, 8-12 women attend the weekly sessions (from a total of 250 women who visit Quai 9, which represents 25 per cent of all substance users).

“A Moment for Women” is not a therapeutic group, but it deals with the problems that women bring in on their visits. Representatives from a rape-victim group and a family-planning service are each present once a month. A prevention kit containing condoms, lubrication gel,

special wipes, hand-wipes, mirror, nail file, tampons, address list and Vita-Merfen is given to women to help improve their self-esteem and to open up discussion. Topics discussed include children, maternity, marital violence, street violence, prostitution, contraception and life in general.

Results/accomplishments

Women regularly attend “A Moment for Women” and generally feel more comfortable talking about intimate issues. The work team has accepted that providing gender-responsive services is part of quality services and the staff is participating in discussions on gender. Condoms, lubricant and information flyers are being used and the prevention kit is very much appreciated. The intervention of the network collaborators is positive, and female staff from various harm reduction services, including Quai 9, provide staff for “A Moment for Women”. The project has attracted media attention, including a published interview, and has achieved recognition by the network. Male clients have become less aggressive.

Challenges

The challenges include achieving genuine support from management and the team; obtaining financial resources; and integrating “A Moment for Women” into the harm reduction service sector in Geneva.

Lessons learned

To successfully put gender-responsive services in place requires the support and dedication of the director and other staff. Through this, and also patience, confidence and perseverance, the concept of gender-oriented services has become accepted.

Europe: Substance abuse treatment services and services for battered women

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The project ran from December 2001 to March 2003 with financing from the European Commission within the framework of the Daphne Programme, and the Ministry of Family, Senior Citizens, Women and Youth of Germany.

Background

The starting point for this project was the close connection between traumatizing experiences of violence and substance use problems; the lack of assistance and counselling to address these two issues; and the unsatisfactory structures for networking and cooperation between substance abuse services and shelters for battered women that results in a cycle of violence and addiction. Often women's experience of violence is not addressed in substance abuse treatment services, which are generally mixed gender. In such settings, women may be confronted with the same structures of power, violence and dependency, leading to treatment drop-out. At the same time, shelters for battered women are not able to address substance use problems and, in most of them, women may not be accepted if they have a substance use problem. If both problems are not dealt with appropriately, women continue in the cycle of violence and addiction, with great potential for re-victimization.

Objectives

The objectives are to develop transnational, interdisciplinary, gender-sensitive criteria and methods for working with women who have experienced violence; to sensitize professionals about the issue of women and addiction and violence and implement gender mainstreaming in mixed-gender teams; to improve the organization of services and the availability of help for affected women; to develop methods to stimulate the development of self-help activities; to involve management in the development and implementation of gender-specific criteria and methods; and to promote cooperation between substance abuse treatment services and women's shelters.

Activities

The project involved the collaboration of services in four countries (Austria, Germany, Ireland and the Netherlands) and six agencies: HeXenHaus-Hilfe für Frauen in Krisensituationen, a counselling centre, women's shelter and assisted living facilities; Drogenberatung Viersen, a traditional, general substance abuse service offering counselling, therapy, prevention and assisted living; SAOL Project Dublin, a community-based service for women in substance abuse treatment, which aims to help women take a healthy role within their communities through development work and capacity-building; CAD Noord-en-Midden-Limburg, Venlo, a general substance abuse treatment service that offers counselling, therapy, prevention, substitution therapy and day and residential services;

Verein Wiener Sozialprojekte in Vienna, a low-threshold facility that provides harm-reduction services, a drop-in centre, assisted living and reintegration; and Verein Dialog, Vienna, a substance abuse service that offers prevention, counselling, therapy and maintenance therapy.

Initial phases of the project involved meetings between cooperating agencies and preparation of a funding application to the European Union; talking to local agencies about the project and exchanging experiences; and seeking political support.

Subsequent phases involved the development of "good practice" models for interdisciplinary work with addicted women who had experienced violence and the development of criteria and standards regarding framework, content, methods and basic attitudes for women-specific interventions, including within mixed-gender institutions.

At the end of the project, a final symposium was held in Bielefeld, Germany, to present the project results.

In addition to women-specific, face-to-face counselling, group interventions were developed by the participating institutions-for example Verein Dialog offered groups for women working in the sex trade, for women wanting to re-enter the labour market and for women in the Vienna police detention centre who had been offered social work interventions. Together with Verein Wiener Sozialprojekte, Dialog has also offered a self-defence course for women.

An evaluation of the project was undertaken with staff and clients of the partner agencies. The staff was asked about networking, gender-sensitive intervention and gender mainstreaming. Women clients were interviewed about their experiences.

Results/accomplishments

The project has reinforced interdisciplinary discussions about the topic of woman-addiction-violence in an innovative way and instigated discussions about the specific needs of women clients in the participating institutions. This has led to more awareness about women, their life experiences and special needs. Gender consciousness has been raised as a result of the discussions and the literature that was reviewed.

Management has become involved in the content-related work of the project and has begun to implement gender-mainstreaming strategies, and professionals have

become more sensitized to the issue through the regional and the professional press.

As a result of transnational cooperation, “good practice” models have been implemented into the practical work of participating partner organizations, and counselling for affected women has been extended and/or improved.

The assumption that women use substances to cope with violence has led to a new perspective, supporting the empowerment of women. This perspective sees women as survivors rather than victims of violence and views substance use as a coping strategy. Women as survivors, not victims, can strengthen their self-esteem and reduce their self-hate and devaluation.

Challenges

Initially, making contact with local women-specific agencies was a challenge, but it was overcome by sending regular information about the project and inviting them to a presentation at the conclusion of the project.

Overcoming conflict between the mixed-gender institutions and the women-specific agencies concerning gender mainstreaming, especially conflict between the mainly male-dominated management and feminist positions, was a problematic issue, yet it was overcome through discussion and by critically reflecting on the different points of views.

Many of the team members in partner agencies needed special training for work with traumatized women. For example, Verein Dialog provided advanced training for employees.

Challenges included implementing this type of project despite the lack of gender-responsive substance abuse treatment services for women; the lack of women-specific counselling and gender awareness among team members; psychological and physical safety issues for women in mixed gender settings; the lack of childcare for women attending substance abuse counselling sessions that was often attributed to lack of demand and resources; and shelters for battered women refusing to admit substance users.

Forming women-specific groups in substance abuse treatment settings was sometimes a problem due to insufficient attendance and because the multi-purpose rooms often used for the women's groups did not provide a good environment. Trying to obtain a room used only by women (men-free rooms) and letting the women adapt these rooms might provide a solution.

Lessons learned

A “top-down” approach (e.g. endorsed and promoted by management) is important in introducing gender mainstreaming; networking activities between women-specific (e.g. shelters for battered women) and addiction-specific services can contribute to the removal of taboos about the subject of addiction and support the development of case-finding. Conversely, it also brings more of a focus on women's experience of violence in addiction-specific services.

Initiating women's groups, even if there are initially no attendees, shows women that there is a place that they can come to. Based on the assumption that such groups need some time to get started in the local network and among the client group, there may be a period of inaction before women begin to attend.

To reach women, substance abuse treatment services need to offer childcare, which signals that a woman's life situation is recognized, that her needs are respected, that she and her children are welcome and that services want to make it possible for women to access them.

South Africa: Adapting an HIV-prevention treatment from the United States of America

Name: South African Initiative: Pilot for the Women-Focused HIV Prevention Study
Country: South Africa
Contact person: Wendee Wechsberg
Contact information: RTI International, 3040 Cornwallis Drive, Hobbs 142, North Carolina, 27709-2194
Telephone: +(1) (919) 541-6422
Fax: +(1) (919) 541-6683
E-mail: wmw@rti.org
Web site: <http://www.rti.org>
Status: non-governmental organization. Study funded by NIDA as supplemental study to larger study implemented in two American inner-city communities.

Background

The United States Government wanted to see if an intervention developed in the United States could be adapted to help women in South Africa who were at risk for substance use and HIV. Preliminary qualitative work confirmed that substances were often used prior to sex work to lower inhibitions and give women courage to approach clients. The rapid spread of HIV and the high AIDS mortality rate among black South African women of childbearing age were often intertwined with substance use and sex risks and further complicated by gender, class and racial differences. It became necessary to develop and evaluate an effective way of addressing the

intersection between substance use, sexual behaviour, sex-related violence and women's risk of HIV.

Objectives

The objectives of the programme were to identify cross-cultural similarities and disparities between inner-city American women and South African women whose substance use put them at increased risk of infection with HIV and sexually transmitted diseases; to determine whether a women-focused HIV prevention programme designed for female African-American crack cocaine abusers could be adapted for use with black South African sex workers who use cocaine; and to replicate and test the effectiveness of the adopted intervention compared with a standard intervention in reducing substance use and HIV risk behaviours.

Activities

Start up: The formative phase of the study involved interviews and focus groups with key stakeholders, including black South African female sex workers with substance use problems, in order to determine the best way to address high-risk behaviours within their cultural context and adapt the intervention. A community advisory board was established with non-governmental organizations, non-professionals, service providers and researchers.

Substance-abusing sex workers from targeted communities were recruited for the study. Eligible participants were asked for their consent for study participation and underwent tests in the field office, such as urine testing for substance use, and assessments for substance use and sexual risk behaviour. Participants were then randomly assigned to one of two interventions, a standard intervention or a women-focused intervention.

An intervention that consisted of two private one-hour sessions held two weeks apart with a staff member where information was provided on HIV; drug and sexual risks; risk-reduction methods, including proper use of male and female condoms; how to talk to a partner about safer sex practices; the HIV antibody test; and steps that participants should take to prevent the spread of HIV. The women-focused intervention included a more personalized assessment of drug and sexual risks, with specific goals developed to help women negotiate risk-reduction skills.

Clients: The clients had to be black South African women, aged 18 years and older, who had tested positive on a cocaine urine test, reported weekly cocaine use

over the past 90 days, engaged in active sex work in the past 90 days or had had multiple sex partners and provided informed consent.

Results/accomplishments

Study results found a decrease in the proportion of women who reported having unprotected sex with paying clients and boyfriends and in the daily use of alcohol and cocaine. Also, daily use of alcohol and cocaine decreased more for women receiving the women-focused intervention than women receiving the standard intervention; and finally, although violence continued to be a problem, women-focused participants reported being victimized less often than women receiving the standard intervention.

Challenges

Creating credibility and trust to conduct outreach was the primary challenge at the beginning of the study, but this was overcome with an 80 per cent follow-up rate after one month. The presence of police, who often raided suspected sex-work areas, made recruitment and also re-contacting study participants difficult. So-called "gatekeepers", often older women who maintained finances and/or offered protection to sex workers, sometimes asked for money or misinformed sex workers about the project. Childcare responsibilities also affected women's ability to attend sessions. Violence against women, the lack of legal employment opportunities and limited access to quality male and female condoms were additional challenges faced during the study.

Lessons learned

HIV and substance use interventions developed in the United States can be effectively adapted to the South African context, including empowerment-based gender and culture-specific interventions designed to reduce women's substance use and sexual risk behaviours and improve their social context; building national and community linkages is important in order to better address women's life contexts and needs; resources are needed to address the major issue of violence; women report needing substance abuse treatment but have difficulty accessing it.

Recommendations for successful approaches and lessons learned

The following recommendations regarding successful approaches and lessons learned reflect the literature

review, case studies and discussions at the meeting of the United Nations Office on Drugs and Crime entitled “Women’s Drug Treatment: Lessons Learned”, held in Vienna from 15 to 17 December 2003.

Political advocacy and networking. Case studies and discussions at the Vienna meeting demonstrate the need for political advocacy and networking with potential partners and stakeholders to increase awareness that gender matters. Political advocacy and networking can also overcome stigma, and establish the need for gender-responsive treatment, both for women and men. To achieve this, advocacy needs to occur at all levels—at the international, national and community levels. Discussions at the Vienna meeting identified the following strategies:

- (a) Advocating at international/national or local policy meetings and groups;
- (b) Using structures such as the United Nations and European Union to develop global or regional plans for funding;
- (c) Having high-profile women speaking out to reduce the stigma of women’s substance use problems;
- (d) Ensuring constant visibility through research, training and women speaking out;
- (e) Raising awareness among groups who lack knowledge, such as the local media, and using case examples that demonstrate cost-effectiveness;
- (f) Having women politicians convey the message that “women are worth the investment” and that successful outcomes have an impact not just on women themselves, but also on their families and communities;
- (g) Advocating at round tables that cut across role levels, e.g. gender mainstreaming needs a “top-down” approach;
- (h) Using mechanisms of general community empowerment to raise awareness; creating alliances with potential partners/stakeholders who can have an impact on project success in the initial planning phases;
- (i) Developing regional cooperation initiatives to sensitize people and raise awareness;
- (j) In communities, using public health messages, peer education, community consultations and advertising of programmes to attract consumers and referral agents.

Epidemiological studies, programme evaluation and research on intervention models. The literature, as well as discussion at the Vienna meeting, identified the lack of

good information about women with substance use problems. There is also a lack of evaluation data on women’s programmes, which is needed to obtain funding, and a lack of basic research on effective treatment interventions for women. The need for research, using a variety of data collection methods (qualitative and quantitative), was identified for the following areas:

- Epidemiological: what substances are used and methods of consumption, taking into account that different cultural contexts may result in different models of substance use patterns among men and women;
- Qualitative research to understand gender ratios among illicit substance users since service utilization data may not reflect actual need;
- Gender-specific needs assessments and the development of instruments and tools appropriate for use with women;
- Treatment research on:
 - Women’s help-seeking behaviours and factors that encourage or discourage help-seeking;
 - Women’s views on service provision to improve treatment access and appropriateness of services to women’s needs;
 - Gender differences in factors/interventions that contribute to treatment engagement, retention and outcomes;
 - Process and outcome evaluation of gender-specific treatment for women.

Adaptation of evidence-based and best practice programme models to the political and sociocultural context of the client population group. As illustrated in the case studies, best practice programme models/guidelines developed in one country can be successfully adapted for use by another country with a different political and sociocultural context. Discussions at the Vienna meeting identified successful approaches that involved becoming informed, staff exchanges, cultural mentoring, taking small steps in adapting models from other countries and ensuring that the language used in describing services is culturally appropriate. Applicability and adaptability of evidence-based interventions and programme models to different countries and cultures may not always involve technology transfer from the developed to the developing world—it may also be in the other direction.

Key points

The key points in chapter 3 are as follows:

- Strategies to promote gender-responsive services for women include attention to gender in national drug strategies and policy development, resource allocation and the development and implementation of best practice recommendations and standards/guidelines for gender-responsive services;
- Promoting gender-responsive services requires political advocacy, networking and linkages at a variety of levels—international, national and community—and within services, including the involvement of management in the promotion of gender mainstreaming;
- Knowledge transfer, training and networking among professionals can facilitate the development or enhancement of services responsive to women's needs;
- Evidence-based interventions developed in one country can be adapted for use in another country.

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4. Engaging women in treatment

Strategies to overcome the barriers discussed in chapter 2 are described in this chapter, as is how to engage women in treatment. These include:

(a) Raising community awareness of substance use problems among women at risk and providing information on available services;

(b) Enhancing the knowledge and skills of those in a position to identify, refer and support women with substance use problems to access treatment. These may include community leaders, community peers, religious leaders or spiritual advisers, primary health-care providers and staff in more specialized settings such as prenatal, child and social welfare and mental health services;

(c) Improving treatment access through outreach and low-threshold services. These latter services are also described under “open access services” in the recent publication *Drug Abuse Treatment and Rehabilitation: a Practical Planning and Implementation Guide* [1].

Community awareness and education

A number of recent reports and articles about women with substance use problems emphasize the need to raise community awareness both about women and substance use in general, and about women with substance use problems and treatment options [2, 3].

Some suggested strategies are as follows:

- Developing awareness material that is informative, non-stigmatizing, accessible and solution-oriented (e.g. information on the location of substance abuse treatment, its cost, criteria for admission and how to obtain a referral);

- Providing information through the media, such as printed material (posters and pamphlets, articles in magazines and newspapers, the telephone directory); radio and television and the World Wide Web;
- Posting information material in a variety of locations where women gather, such as health services, shops and stores, community centres, places of worship, workplaces and other culturally relevant settings;
- Holding community forums that provide information and education on the topic;
- Training community volunteers, building on/linking to existing services for women. (This is particularly effective where few if any help structures exist.)

Awareness and education activities that reduce stigma and empower communities to address women’s substance use problems are illustrated by a number of case studies, particularly work with women’s associations in Senegal, and with Afghan women in Afghanistan and Pakistan, described in this chapter. These projects demonstrate that reaching out to communities, raising awareness about women’s substance use problems and providing information about available treatment services can overcome taboos and increase women’s access to treatment.

Training primary-care and other helping professionals

In general, women use health services to a greater extent than men. Women with substance use problems often make initial contact with services other than the specialized substance abuse treatment services. For example, they may visit their doctor or other primary health-care worker for routine health care, seek counselling services for family or mental health problems, seek specialized medical services such as

prenatal or gynaecological care or come to the attention of child-welfare authorities or the criminal justice system.

Training staff in these settings to routinely screen for substance use problems, and referring or briefly intervening when problems are identified can contribute to improved outcome, particularly if intervention occurs at an earlier stage of problem use. Training should address not only knowledge and skill acquisition, but also attitudes and beliefs about women with substance use problems and the effectiveness of treatment. A survey of women in treatment found that the majority (74 per cent) of women believed it was appropriate for doctors and other health workers to routinely ask their clients about their use of alcohol and other drugs and to offer advice and support. Only 8 per cent said it was not appropriate, while 10 per cent said it depended on the circumstances [4].

One initiative in the United States is described in box 7.

BOX 7

TRAINING PRIMARY-CARE WORKERS:
UNITED STATES PRIMARY-CARE INITIATIVE

Focusing on primary-care providers is important because women are most likely to use these services. In the United States, the National Institute on Drug Abuse has recently launched a primary-care initiative to address training issues. It includes a physician outreach initiative to involve primary health-care providers in the early recognition and assessment of, and intervention with, substance-abusing adolescents and their families.

Screening methods can involve asking some standard questions about use of substances, or administering a standardized screening instrument. Screening may be done as part of a routine physical or psychosocial assessment or in a discussion of strategies that women use to cope with stress. Whatever method is used, screening should be done using a non-judgemental approach to substance use that encourages discussion of any problems. One example of a general screening instrument is provided in annex IV of the publication *Drug Abuse Treatment and Rehabilitation: a Practical Planning and Implementation Guide* [1]. Other examples of screening instruments are discussed in the Treatment Improvement Protocol series entitled “Substance Abuse Treatment: Addressing the Specific Needs of Women”, to be published by the Center for Substance Abuse Treatment of the United States. As with assessment instruments discussed

in the next chapter, screening instruments developed for use in one country or cultural context need to be appropriately adapted for use in other languages and cultures.

Networking and linking with other services

As noted in the previous chapter, people with substance use problems often have an array of needs that cannot be addressed by a single service. For women, coordination and collaboration between substance abuse treatment services and prenatal and obstetric/gynaecological services, child welfare/protection services, crisis services, such as women’s shelters or sexual assault services, and mental health (including trauma) services are particularly crucial. In addition, different services will be required at different phases of the client’s treatment for substance use problems. For example, in the aftercare phase, linkages with skills development, employment and housing services are important, though safe housing options are also required by women in non-residential treatment.

Providing training is one approach to networking and linking. Training can be reinforced by other linking activities such as collaboration between sectors to develop best-practice models for addressing dual problems (e.g. women with substance problems who have experienced violence); shared or cross-training between sectors (e.g. HIV/AIDS treatment services and substance abuse treatment services); having substance abuse treatment staff work from a health or social service agency or vice versa; visiting primary-care or other service providers to explain the needs and services required by women receiving substance abuse treatment services; and developing partnership agreements between services that have mutual clients. Becker and Duffy [5] discusses strategies for linking with other services, as does Charnaud [6]. Several case studies also illustrate these activities such as “Addiction as a Chance of Survival for Women with Experience of Violence”, and “A Moment for Women”, both described in the previous chapter. Breaking the cycle, described in the next chapter, provides an example of a “single access model” with a number of different agencies coming together to provide comprehensive services for pregnant and parenting women.

Outreach services

Outreach services can be defined as those services provided beyond the usual boundaries of agency activity in order to reach out and engage individuals who have or are at risk of developing a substance use or related health

problem. The focus of outreach services is often on reaching those who are “hard to reach or hidden” and not in contact with other services. However, outreach activities may also be designed to reach people already in contact with helping services but who require accessible substance abuse treatment services. The development of outreach services should be based on a careful assessment of the characteristics, life circumstances and needs of the specific group who will receive the services. In some cultures, men and women live more segregated lives and this must be taken into account in planning outreach services. Particularly for services designed to reach women engaged in sex work or homeless women, physical safety should be the primary consideration in planning these services.

Outreach activities may occur in women’s homes, on the street or the open drug scene, cafes, bars, drop-in or storefront agencies, police stations, shelters, community agencies, places of worship, hospitals, prisons, social and health-care settings or in any natural setting where women gather.

Outreach may be done by telephone and/or be delivered by mobile vans or cars, or by programmes establishing satellite offices in accessible locations.

To establish trust, continuity is important for recipients of outreach services, particularly for clients who are at high risk, such as women who are involved in sex work and inject drugs or who are living in violent situations.

BOX 8

STRATEGIES TO ENGAGE AND RETAIN WOMEN IN TREATMENT

A report on improving treatment engagement and retention of women with substance use problems [5] has been published by the Home Office of the United Kingdom. The report describes five different types of “outreach” work in the case study organizations contacted for the study. These are: home visiting particularly for women with children or women who are pregnant; pre-care and aftercare for women preparing to enter residential treatment and for women after they have left residential treatment; services aimed at sex workers; work in local communities providing drug services from the premises of other community-based services; and working with women involved in court proceedings.

The report also identifies strategies for working with women clients and for making stronger links with key partners.

The case study on work with Afghan women in Kabul, described later in this chapter, illustrates strategies for reaching out to women in their homes in a culture where women’s lives are much more circumscribed.

Box 8 describes different types of outreach activities designed to engage and retain women in treatment.

Peer outreach

Peer outreach can be an effective way of reaching women who are not in contact with professional services, who live in societies with strong cultural taboos against substance use by women or who are in more marginalized circumstances, such as women who inject drugs or women engaged in sex work. Literature on the subject suggests that among some groups, peers may be viewed as more credible, and women who use substances may find it easier to establish trust and discuss personal issues with peers. Peer outreach workers can provide users with information on how to reduce risk behaviours, teach by example and link substance users with substance abuse treatment and other health and social services.

As demonstrated in several of the case studies described below, peers may be women living in the same community, or they may be former or current substance users. Women who have successfully completed treatment can be role models and provide support to women during the treatment process. “12-step” work undertaken by members of Alcoholics Anonymous or Narcotics Anonymous is a well established form of peer outreach in countries where 12-step mutual aid groups are established.

In box 9, two research studies on outreach with people with substance use problems are described.

Some countries have drug user organizations that are involved in providing direct client services. Two examples are Australia and the Netherlands. In the Netherlands, the Mainline Foundation, located in Amsterdam, provides information to “hard drug users” and publishes a magazine that annually produces an issue specifically for women substance users. In Australia, the Government funds drug user groups that provide frontline services, produce regular newsletters and represent substance users in various governmental and non-governmental committees and forums (e.g. the Australian Injecting and Illegal Drug Users’ League. (www.aivl.org.au/)).

BOX 9

RESEARCH ON OUTREACH

A study that compared a peer-delivered intervention to a standard intervention in reducing HIV risk behaviours among out-of-treatment substance abusers in the United States of America, found that individuals in the peer-delivered interventions were more likely to change behaviours related to cocaine use and number of sex partners, but not condom use. When examined by gender, though women in the peer-delivered intervention showed a trend towards improvement over women in the standard intervention in these two areas, the differences were not statistically significant, leading the authors to suggest that interventions for women should be tailored separately to meet their different needs [7].

In another study of the effectiveness of street outreach services in linking injecting drug users with medical services, though not gender-specific, the findings indicated that clients who had four or more contacts with street outreach workers during the preceding six months were more likely to act on referrals. The authors suggested that cross-training between outreach programmes and social services agencies could improve the effectiveness of outreach services in linking their clients with health services, and that the training should focus on: strategies for increasing contact with less visible injecting drug users, coordination of multiple agency outreach activities in terms of coverage and services, identifying and overcoming barriers to seeking medical services, techniques for tracking referrals, reporting of physical and sexual abuse, advocating for clients services such as aftercare, dental care and prenatal care, incorporating case management into outreach programmes, and the relationship between sexually transmitted diseases and HIV transmission [8].

BOX 10

USE OF PEER EDUCATORS IN THE ISLAMIC REPUBLIC OF IRAN

The role of peer educators and the advantages of providing community-based services are demonstrated through the work of a drop-in centre in Kermanshah, Islamic Republic of Iran, called Health Club of Toopkhaneh. The centre has been successful in engaging women and overcoming barriers of tradition and culture. The centre distributes needles/syringes, condoms and information and provides primary health care for injecting drug users on the street. It serves both women and men and currently employs five women, formerly injecting drug users, as peer educators. The women, who have been abstinent for 5-7 months, achieved abstinence supported by a form of "network therapy" provided through the "subculture" of the drop-in centre with two male addicts as their main educators.

Peer educators are engaged in basic knowledge transmission and safe disposal of used needles and syringes in the neighbourhood of the drop-in centre. In addition, they participate in group therapy as clients and as co-therapists, provide nursing care during client detoxification, participate in lifestyle education sessions and discussions and have formed a therapeutic network for injecting drug users and former drug users.

Support for social reintegration through income generation activities is an important activity for the women peer educators, some of whom employ other female injecting drug users. One has a carpet-making room with five women injecting drug users working with her, and another employs three women who are former injecting drug users and engaged in sex work. The remaining peer counsellors also work at carpet weaving. Primary investment for such income-generating activities is provided by the local businesses in the bazaar in which the drop-in centre is located. Advantages of the centre as a community-based service over traditional services include the ability to follow up women, reduction in the stigma attached to women's problem substance use and the increased respect that women receive in the community, which has mobilized to support them, for example, through investment in their income-generating projects.

In box 10, a drop-in centre in the Islamic Republic of Iran is described; it involves peers who are former substance users.

Low-threshold services

Low-threshold services are designed to maximize contact and access by not requiring clients to stop using sub-

stances, determining where substance users gather, offer a drop-in rather than appointment-based service, not requiring clients to identify themselves, offering basic "survival" services and opening at convenient times. They may also take their services off-site by using vans or buses and outreach work. As with all service development, the characteristics and needs of the target group must be assessed, as well as the support from key stakeholders such as the police. The Federal Office of Public

Health in Switzerland has developed guidelines for gender-responsive low-threshold services (see chapter 3).

The literature indicates that low-threshold services typically work with a highly vulnerable group of clients who usually have long histories of poly-substance abuse and multiple health and psychosocial problems. Women are often involved in sex work and have little support and few resources. If they have had past involvement with mainstream services, they have often lost that contact. They are often vulnerable to violence from their male sex partners or from other men such as pimps and have little power to change to safer behaviours.

Many low-threshold services were initiated in response to the spread of HIV/AIDS among injecting drug users and sex workers, focusing on reducing high-risk behaviours (sharing needles or having unprotected sex) by distributing clean needles and other sterile injecting equipment, collecting used needles and syringes, distributing condoms and providing information on safer injecting practices and safer sex practices. Some also work with those who are homeless. Low-threshold services may offer other practical services such as food, shelter, washing

and laundry facilities, health information, access to medical care (including drug substitution treatment) and referrals. For example, in Germany, low-threshold services dispense methadone. To address these multiple needs, low-threshold services need to actively network for services that they do not provide on site, such as health care (including services for HIV/AIDS and hepatitis), social services, emergency shelter and housing, vocational services and substance abuse counselling, and that are accessible and appropriate to their women clients.

Women-specific objectives for low-threshold services identified in a project of the European Union “Pompidou Group” are described in box 11.

Case studies

Engaging women in treatment

The first two case studies illustrate how communities can be mobilized through awareness and education to overcome strong cultural taboos and address substance

BOX 11

WOMEN-SPECIFIC OBJECTIVES/SERVICES FOR LOW-THRESHOLD SERVICES

In Europe the “Pompidou Group” [3] undertook a project entitled “Problem drug use by women: focus on community-based interventions”. A sample of nine low-threshold services contacted as part of the project identified the following women-specific objectives or services:

- Safety/protection from violence, a place where women can rest and are not pressured by male partners or other men in their lives such as sex partners;
- Health care and women-specific health promotion, either in-house or through active referral networks—gynaecological care was identified as being particularly important;
- Harm-reduction information to reduce women’s risk of contracting blood-borne diseases by providing specific information on safer injecting and safer sexual practices;
- Crisis intervention: staff of some services have been trained to provide immediate assistance to women who have been sexually or physically abused;
- Motivational counselling, case management and “qualified” referral, recognizing the importance of developing a trusting relationship with women clients, in order to work in the context of the priorities and needs they identify and to make appropriate referrals. A relationship with a particular worker was also seen as important.

The report noted the need for staff to be knowledgeable about the life situations of women with substance use problems and respectful of the “self-expertise” of their women clients. Required skills in crisis intervention, sexual abuse counselling, relationship counselling and transference issues, as well as a high degree of professionalism, were also identified as being important.

use problems among women in Afghanistan, Pakistan and Senegal. Both projects also have strong training components for those involved in providing prevention, treatment and aftercare to affected women.

The next two case studies illustrate outreach and low-threshold work. The "Protect Yourself" outreach service in Slovakia provides gender-specific components as part of a mixed-gender street outreach service. In Germany, the low-threshold projects Frauenberatungsstelle and Frauencafé are part of a women-only service. Both of these projects work with women who are at high risk because of their injecting drug use and involvement in sex work.

Afghanistan and Pakistan: Developing community-based services for Afghan women

Name: Drug demand information, advice and training services for Afghan women in refugee camps in Baluchistan and North West Frontier Province (NWFP), Pakistan and the provision of treatment for Afghan women at the Nejat Centre in Kabul.

Countries: 1. Pakistan; 2. Afghanistan.

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Status: Both projects are non-governmental organizations with time-limited international funding. The project in Pakistan has been in operation for 18 months and the project in Kabul for 2 months.

Background

During a visit by United Nations drug demand reduction staff in 1999 to a camp for Afghan refugees in Pakistan, women living in the camp requested help for their substance use problems. Following this request, an in-depth assessment of the situation of Afghan women living in refugee camps in Baluchistan and the North-West Frontier Province of Pakistan was carried out. The assessment involved interviews with teachers, doctors, non-governmental organizations workers, community elders, religious leaders, community members, women using substances and their families. The needs assessment indicated that abuse of illicit substances and pharmaceutical substances was common. Problem substances included opium, tobacco, tranquillizers, painkillers and sleeping pills.

Three groups of Afghan women were identified with substance use problems that had developed for different reasons. The first group consisted of carpet weavers who had developed backache from weaving and treated their pain with opium. Among the members of that group, it was reported that several pregnant women had lost their babies while suffering withdrawal from opium, and babies of other women experienced neonatal abstinence syndrome. A second group of women traditionally used opium to "treat" a variety of health problems and to keep out the cold during the winter. In this group whole families smoked opium together. Some women stopped using opium in the refugee camps and their health returned. A third group of women had been severely affected by the trauma of war; the abuse of opium and pharmaceuticals was common. Following detoxification, their trauma symptoms, including serious depression, often reoccurred.

The need for women's services was also evident in Kabul following the departure of the Taliban. Nejat, a substance abuse treatment centre, had already been providing services for several years to Afghan refugees in Peshawar, Pakistan, Afghan refugee men being the main client group; subsequently a centre was opened in Kabul for male addicts. A needs assessment conducted in the Kabul community found that there was also a substance use problem among women that needed to be addressed.

The majority of women using the services of Nejat are between 15 and 25 years old, but some are older. As with some of the women in refugee camps in Pakistan, their substance use problems are mainly associated with the experience of living with war or conflict for many years. Most women use opium and/or tranquillizers; about 5 per cent use cannabis resin and 5 per cent alcohol. A few women inject the analgesic pentazocine.

Objectives

The objectives are to reduce and prevent the misuse or abuse of substances among Afghan women in selected refugee camps in Pakistan and also in Kabul, to improve the capacity of health-care professionals, social workers, teachers, community development workers and community groups working with women in targeted refugee camps in Pakistan to address the misuse and abuse of substances and related health-care issues and to reach women in Kabul who have a substance use problem and support them in making behavioural changes and reintegrating into society.

Activities

In Pakistan, five major project activities followed the initial needs assessment:

Training and capacity-building for substance abuse prevention: The project had a large training component with two-day training workshops on skills in substance abuse prevention, which provided information on substances, life skills and prevention of substance use problems, using methods such as lectures, brainstorming, small group work and role-playing. These initial workshops were followed up by further support sessions and the provision of technical support and awareness-raising material. The workshop participants included groups of women activists living in the refugee camps, community workers, health professionals, community development workers and schoolteachers.

Development of awareness raising materials: A variety of different posters were developed by the project for women using substances and women at risk of developing substance use problems, as well as for refugees who were being repatriated.

Community-based rehabilitation: This aspect of the project involved training community workers, health workers and staff from non-governmental organizations in community-based rehabilitation for women with substance use problems. It included relapse prevention techniques, facilitating the establishment of rehabilitation services for women in the refugee camps, and providing ongoing technical support so the programmes would be sustainable. *Purdah* is strictly observed among Afghan communities and women are not allowed to go to other places or houses alone. Therefore, women with substance use problems are either referred to treatment centres in Pakistan with separate facilities for women or they are detoxified at home. As part of community-based rehabilitation, women carpet weavers were also taught skills and techniques to address health problems related to weaving, such as backache, as well as how to care for their children while they were engaged in weaving.

Income generation: This income-generating aspect of the project was designed to address the needs of women who had been detoxified and women at risk for substance use problems who could participate in income-generating activities. Activities included an initial needs assessment, refining their existing skills, training women in new skills for income generation and supporting and facilitating their efforts to produce and market materials and establish small businesses.

Networking: Networking involved establishing linkages among health and social services and refugee community groups in the camps, coordinating and facilitating joint activities and establishing linkages with organizations working in Afghanistan such as Office of the United Nations High Commissioner for Refugees (UNHCR), as well as with groups in Pakistan who could provide specific services, such as assistance for opium-dependent pregnant women and their newborn babies.

In Kabul, services were provided to women by Nejat essentially in four stages:

- First contact—provides women in general with information on the consequences of substance use (basic drug awareness education), how to improve family and environmental hygiene, and general health information such as protection against diarrhoea for young children; advice about keeping young children warm in cold weather; advice about schooling for children to prevent them from roaming the streets; and advice for pregnant women and women who are breastfeeding.
- Pre-treatment stage—women already dependent on substances are provided with motivational counselling for a three-month period during which the short- and long-term impact and risks of substance use on health, social relationships and financial status are discussed. During this stage, the possibility of treatment is also discussed, although some women reduce their substance use or stop using substances altogether.
- Detoxification and treatment stage—lasts for one month and includes symptomatic treatment with analgesics if necessary (brufen/paracetamol/diclofenac), provision of foodstuffs such as cooking oil, rice and sugar if resources are available, provision of soap and shampoo and continuous motivational counselling.
- Aftercare stage—female staff provide follow-up for one year. In the first three months women are visited in their homes every 10 days; in the second three months, every two weeks; and in the last six months, once a month. The main focus is on maintaining their well-being so that the women will not feel neglected. Advice is given on improving family relationships, relapse prevention and other problems that may arise.

The programme has tried to find the underlying causes of substance use and focuses on positive success stories in working with women clients. It is estimated that 20 per cent of the work is medical and 80 per cent

psychosocial. The programme has seven female staff who received on-the-job training. In addition, basic training and a short stress management workshop have been provided through the project. The project has also promoted a drug awareness programme for women and the community and established volunteer groups of recovering women and other community members to work with women with substance use problems and their families.

Results/accomplishments

Pakistan

- Women activists in refugee camps, as well as social workers, health-care workers, community workers and field workers from non-governmental organizations have been trained in substance abuse prevention and have become involved in activities to increase awareness among women about substances, particularly opium and tranquillizers: a total of 1,304 individuals (1,269 women) have received training in primary prevention;
- 35 health-care professionals have been trained in community-based substance abuse treatment and rehabilitation;
- 85 women registered for substance abuse treatment in the four refugee camps in Peshawar; and 20 women were referred to substance abuse treatment centres outside the refugee camps;
- 80 women's councils have been established in refugee camps to undertake prevention and income-generating activities, and 230 women have participated in income-generating projects;
- 23 women carpet weavers participated in the special training programme designed to teach them techniques and skills to reduce health problems related to weaving.

Kabul

- Over 4,000 women have been contacted and provided with general health-care advice and basic drug awareness;
- 325 women substance users have been treated;
- Women have stopped using substances and have been reunited with their families;
- Particularly successful aspects of the project include motivational counselling, awareness training for community leaders and the dedication of the staff.

Challenges

Pakistan

The traditional tribal nature of Afghan society, particularly in relation to substance use problems among women, was one of several challenges in Pakistan. There was also a lack of available services that address substance use and related problems that women were experiencing. This was made more difficult by the absence of substance abuse prevention services for males. However, a positive approach and the involvement of the male population in the project helped project workers to overcome these problems.

High illiteracy rates among women in general and among the women activists who became involved with the project were also a problem. Finally, the Afghan community's dependency on external aid made it difficult to encourage participants to work for themselves and their communities.

Kabul

The general atmosphere of suspicion and lack of trust existing in post-conflict Kabul, together with the shame and stigma experienced by women substance users and their unwillingness to disclose their problem to family members, proved to be a challenge for the programme. About 30 per cent of husbands forbade their wives to use the programme's outreach service. Economic problems, such as lack of funding (and trained staff), inadequate transportation to facilitate home visits and the extreme poverty of women clients, who expected the programme to supply commodities such as food and clothing, were difficult to overcome.

Lessons learned

Pakistan

A high degree of community support can be achieved by involving community members in the assessment, development and implementation of a project. From the start, this involvement gave the community a feeling of ownership of the problem. It is also important to learn about the norms and values of a community; having respect for these norms is required to run a successful programme. Addressing substance use problems among Afghan women and empowering communities to prevent women's substance use problems require treatment managers to encourage community-based treatment and rehabilitation and projects that provide women with income-generating skills. It was noted that premature termination of project funding could result in frustration in the community.

Kabul

To approach the community in Kabul, several precautions need to be taken. Staff should have an existing family contact before entering a house, and a male social worker should accompany female staff for safety and security reasons. Before discussing substance use, in order to gain the confidence of women clients, staff should begin with a discussion of general health problems (for several days or weeks if necessary). If a man in the family is identified as having a substance use problem, it is essential to involve a male worker.

Senegal: Overcoming cultural taboos through women's associations

Name: Fangandiku Dorog: to protect against drugs-Support programme to women's associations fighting against drug abuse

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Status: Non-governmental organization with ongoing international funding and operating for four years

Background

An assessment of the substance abuse situation in the Senegalese communities conducted by the Association pour la promotion du centre de sensibilisation et d'information sur les drogues (APSCID) indicated the need for effective prevention and treatment interventions for youth and women. The rural areas of the country had no treatment centres and lacked trained personnel to educate the community about the health risks of substance use and the consumption of illicit local brews. Following an awareness-raising campaign in these communities, it became evident from women and from their families that there was an increasing need to address women's substance use problems, that there was a lack of adequate services for women and that women who received treatment relapsed frequently because they did not receive aftercare.

The majority of women with substance use problems are aged between 35 and 55 years, the main problem substances being cannabis and illicit local brews; multiple substance use was common. Many women live in towns, are single parents and some also work in the sex industry.

Specific barriers that women experience in accessing treatment include:

- (a) Stigmatization and denial of women's substance use problems by health-care workers, which results in the women's isolation and secrecy;
- (b) Difficulty in obtaining residential treatment due to the lack of treatment centres in Senegal, and because cultural norms, particularly in rural areas, do not permit women to go to treatment centres;
- (c) A woman's dependency on her husband or his family's income to pay for treatment;
- (d) Hesitancy to go to treatment because of lack of confidence in male therapists, which also contributes to treatment drop-out;
- (e) Fear experienced by pregnant, substance-using women that their babies will be taken from them; as a result they access care late in their pregnancies;
- (f) Mothers not wanting to go to treatment for fear that they will lose custody of their children;
- (g) Women's low self-esteem and fear of being judged by society as bad women and mothers.

Objectives

The objectives were to strengthen the organizational and programme capacity of women's associations in all the regions of Senegal to ensure the sustainability of substance abuse prevention activities; to train women to provide information on prevention and treatment to their communities (peer-to-peer approach); to promote behavioural change for women with substance use problems; to involve women's associations and women in the community in the aftercare and reintegration of women with substance use problems.

Activities

The first step of APSCID was to organize meetings and community-awareness days with women's and young people's associations and establish information, education and awareness plans with community leaders. Next, APSCID identified the most active women's associations for follow-up. Leaders in these women's associations participated in "train-the-trainers" workshops and then in turn trained women in their local communities to identify and support women with substance use problems. APSCID has also promoted communication and collaboration between treatment professionals in the Dakar area (where women go for treatment) and local women's associations in order to help them link women with substance use problems to treatment.

Women's associations have also become involved in providing aftercare with the support of the psychiatric facilities in the Dakar area, which visit local communities when needed.

Results/accomplishments

Women's associations have a basic knowledge about prevention and treatment; community leaders and local politicians have been informed about the need to provide treatment to women, especially pregnant women; increasingly more women are accessing treatment centres; substance abuse treatment interventions have been adapted to the needs of women, and follow-up care after the detoxification phase is being provided. This includes psychosocial interventions and, where necessary, pharmacotherapy. The project has also resulted in improved collaboration between the prevention and treatment sectors, which are now seen as complementary.

Key factors that have made this project successful include its consistency with the demand reduction components of the National Action Plan for Drug Control in Senegal; the support of the Inter-ministerial Committee against Drugs; the active participation of families and communities (including men and young people's associations) in taking care of women with substance use problems; being able to engage women in the community in awareness-raising and aftercare to support women who want to end their substance use; the involvement of women's associations in the national demand reduction policy; the cooperation of psychiatric hospitals in Dakar; and involvement of women social workers.

Challenges

The main challenge for this project has been to overcome the cultural, religious and social beliefs and patterns that do not empower women. Another major challenge has been to develop a strategy and approach for treating women with substance use problems in order to improve the care they receive.

Lessons learned

Increasing community awareness can reduce the stigma for women with substance use problems and create community confidence in treatment services. Community leaders and local politicians should be encouraged to play a role in facilitating discussion about women's substance use problems and in overcoming community taboos. Women in rural areas can be empowered to understand their leadership role in social and cultural

issues and to lead discussions on substance abuse prevention, treatment and aftercare in their communities.

Promoting the health of women through substance abuse treatment has an impact not only on the health of individual women, but also on the health and survival of their families and the community. The needs of women with substance use problems are very individual and sometimes difficult to address, but women need to be informed and supported to assume responsibility for their own change. Detoxification is not sufficient and should be followed by psychosocial treatment and possibly rehabilitation.

Germany: A continuum of care for women

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Status: non-governmental organization with ongoing funding; years of operation: 15 years for the Counselling Centre and 8 years for the Women's Café

Background

At the time the service was established, there was concern about the spread of HIV/AIDS, especially its prevention among substance-using sex workers, and the lack of services for this group of women. There had also been a series of violent attacks against women substance-using sex workers, who were perceived as a threat. A large number of the women were also homeless, which made it difficult for them to follow HIV prevention advice. While at the beginning, female sex workers were the main client group, this has now shifted towards substance dependence of women in general.

Objectives

The overall goal of this project is to reach out to substance-dependent women of all age groups and to rehabilitate and reintegrate them into society by maintaining contact with them, establishing a relationship, initiating counselling and case management, getting them involved in different activities such as caring for their physical and psychological health, providing skills training and

art therapy and helping them to find a place to sleep or new accommodations.

Specific objectives are:

- To reduce risk behaviours and prevent infectious diseases and other substance-related health risks;
- To reduce risks related to sex work;
- To improve client health, by providing services such as opioid maintenance treatment;
- To motivate and support clients to make life changes;
- To facilitate the social reintegration of substance-dependent women in general, as well as those who are sex workers, by providing housing, medical care (methadone maintenance) and training in social skills.

Activities

A needs assessment of the situation of sex workers using substances was undertaken with agencies working in the field of substance abuse, a self-help group of sex workers and the municipal health authorities. Contact was also made with the police. A proposal was developed and funded as a pilot project, which subsequently received ongoing municipal and state funding. Receiving start-up pilot project funding was decisive for the successful implementation of the project since it was felt necessary to establish a separate women's service rather than a women-only component of an existing mixed-gender service.

Frauenberatungsstelle provides a range of services including low-threshold services/day care through a women's café, Frauencafé, and outreach using a bus; counselling—case management of substance-dependent women; a specific risk-behaviour-oriented intervention project for AIDS prevention among female sex workers; methadone maintenance dispensary for 30 women; social skill training for substance-dependent women, including art therapy; workplace counselling and support for reintegration into the workforce; and counselling and reintegration with medium-term housing for 27 women.

The project serves only women with a focus on those with long-term substance dependence, poly-drug use, homelessness, high prevalence of chronic illness such as hepatitis C, HIV/AIDS and other physical health and mental health problems and substance-dependent female sex workers.

Results/accomplishments

Frauenberatungsstelle (Women's Counselling Centre) has provided a wide range of services for substance-dependent women who have strong affiliations to the drug scene in Frankfurt and the red light district of the city. It has provided safe places for substance-dependent women, such as the Café, the counselling centre and the housing area. All projects of the Frauenberatungsstelle attract a large number of substance-dependent women who bond easily with the female counsellors. It has been shown that women maintain long-term contact with the Frauenberatungsstelle, especially those who stabilize on methadone and enter into one of the housing projects.

The rate of referrals to residential substance abuse treatment has increased over the years. Skill-training groups have increased in importance, as has training clients to enter the workforce.

The project is evaluated yearly by the municipality, which presents its statistics and reports on case management and documents details of its activities.

Challenges

The major challenge for the project relates to funding, which is provided by the municipality. In times of dwindling funding, the pressure to document successes increases. However, women with long-term substance use problems and chronic illnesses and other mental disorders have rather low success rates when using outcome measures such as abstinence or financial support. Thus, the project struggles to renew its funding on a yearly basis and has to come to terms with decreasing financial support from the municipality.

Lessons learned

When starting a project that addresses a highly stigmatized group of women, such as women with substance use problems working in the sex trade, it is wise to do this in an encouraging environment. Examples include a safe place where women can meet, talk and have contact with female counsellors, and where trust can be established; access to first aid; and aids for safe sex and safer substance use and medical services such as methadone treatment. Once the project is established, it can expand to include a wider variety of different and specialized services, which change over time according to the changing needs of female clients.

Finally, clients require concrete help such as housing, skills training, on-the-job training and assistance to reintegrate into society.

Slovakia: Trust on the streets

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 Web site: www.odysseus.net
 Status: non-governmental organization with funding from a variety of sources including the local municipality, State funding and funding foundations; years of operation: six years

Background

Slovakia, and in particular its capital Bratislava, experienced a rapid increase in problem substance use in the early 1990s, when patterns of consumption shifted from solvents, hypnotics and sedatives to injecting heroin. An explosive growth in the number of treated opiate addicts has been registered in the country since 1994. Until 1995, most of those treated were residents of Bratislava, but the spread of the heroin epidemic throughout the country has been confirmed by an increased percentage of clients outside the capital.

In 1997, nearly 80 per cent of all drug dependency treatment was related to opiate and/or heroin use; most clients were drug injectors, and about two thirds of clients were aged 24 years or younger. In 1994 the first fixed-site needle exchange programme and in 1997 the first methadone programme were established in Bratislava, but no outreach or other low-threshold services existed. Prior to the launch of "Protect yourself", staff visited street prostitution and drug consumption areas and established contact with their future clients. It became apparent that existing services were either not known to them or that the threshold of those services was too high. Since there was no other programme providing assistance to street sex workers, who work under very poor conditions, the initiative was much welcomed. "Protect yourself" is a project of the non-governmental organization Odysseus, which provides a range of harm-reduction, outreach, self-help, advocacy and information services, mainly to substance users and sex workers.

Objectives

The project's objectives were as follows: to reduce the health consequences of substance use and sex work (HIV/AIDS, hepatitis B and C and other blood-borne

and sexually transmitted infections) among the target groups; to establish and maintain contact with the target groups; to increase access to relevant information on substance use for injecting drug users and sex workers, HIV/AIDS and sexually transmitted infections, and the means of protection; to reduce the frequency of unprotected sexual intercourse; and to increase the contact of injecting drug users and sex workers with the health-care system and social services.

Activities

Services: The project "Protect yourself" was the first in Slovakia to provide outreach and needle exchange services on the street. It operates on Sunday, Monday and from Wednesday to Friday in four areas in the centre of Bratislava, including two areas that are known for street prostitution. Since 2003, services have also been provided in the town of Puchov. In Puchov, a peer outreach approach is used involving active drug users, while in Bratislava, outreach workers are not part of the target group (e.g. active users). In addition to outreach workers walking the streets, there is a mobile unit that operates in two other areas of Bratislava, while in Puchov, clients can make contact by telephone.

Street workers work in pairs, carrying their materials in two big black bags, which have become a "signal" to clients. They also carry a container for used syringes and needles, on which the name of the project appears. The street work is done in the late afternoon and the evening, with areas of prostitution usually visited by the team in the evenings. Staff reliability, stability and their working hours are appreciated by the clients. The female sex workers appreciate that they can establish ongoing contact with staff members.

The following services are provided:

- Distribution of educational materials on safer sex and safer injecting, in addition to condoms and lubricants;
- Information and discussions on reducing the harm arising from substance use and sexual behaviour;
- Distribution and exchange of sterile needles and syringes and other materials for safer injecting (e.g. alcohol swabs, dry swabs, filters, water, ascorbic acid and powder) and removal of used syringes from circulation;
- Referrals to social and health-care services with special agreements being made with these services for women clients, as well as social assistance;

- A magazine—*Intoxi*, which always includes a section specifically for women clients;
- Booklets distributed to clients including “Chran sa sam” (Protect yourself), on safer injecting practices; “Bezpečnosť pri práci” (Safety at work), to inform female sex workers about safer sex work; “Infekcia HIV ochorenie AIDS” (HIV infection, AIDS illness); “Chlapci z ulice”, to inform male sex workers about safety at work and the use of condoms; and other booklets in comic book format. There are also many other education leaflets produced in other design formats on the most relevant issues such as hepatitis, piercing and tattooing, sniffing and syphilis.
- “Protect yourself” has also provided HIV (as short projects in the period 1999-2000 and in 2002) and syphilis anti-bodies testing (ongoing since 2002).

In 2003, Podchod, a low-threshold club only for female sex workers, was established. The aim of the club, which is located in the area known for street sex work, is to provide a safe and comfortable space where women can drop in for tea or coffee, to chat or just to sit for a while. The development plans include having separate hours just for women, which would also provide support for starting a self-help group or organization.

Staff: The team consists of 13 street workers (4 male and 9 female, including a project coordinator and an assistant) and one social assistant.

Clients: The average age of clients is 20-25 years, the main substances of choice being heroin and Pervitin (a methamphetamine); women represent 5-53 per cent of clients, depending on the outreach location. No formal documentation is required to participate in the programme.

Results/accomplishments

Since the start of the project, outreach workers have made 38,327 contacts with the target groups, collected 508,233 used needles and syringes and distributed 626,302 sterile needles and syringes. Those data only cover the project in Bratislava, as statistics differ in Puchov.

Challenges

In Slovakia there are many challenges to providing gender-sensitive services. There is a lack of low-threshold outreach services overall, with only one in Slovakia

specifically for women, and high-threshold criteria exist for access to social services. There are few trained and sensitive staff, male or female, and there is no gender-sensitive training in the Slovak language. There is a lack of funding for women’s projects, particularly projects that address substance use and sex work.

Women suffer from low self-esteem and face rejection from families and communities and must also deal with substance abuse “experts” who are often males. Furthermore, substance use problems are treated as medical problems, without giving attention to social issues, and some substance abuse services have a more punitive than supportive approach. Women are also confronted with societal stigmatization of substance use problems and are not allowed “lapses” in behaviour, which includes substance use.

Finally, changes in the social and health-care system are necessary to alleviate the financial burden for people living on the street.

Lessons learned

Outreach is an effective way to establish contact and relationships with injecting drug users and sex workers and to distribute sterile injecting materials and information on safe injecting and HIV among groups that do not take advantage of other services. It is necessary to have professionally trained and paid street workers, and ongoing training and supervision of the staff are necessary, especially to prevent “burnout”.

It is important that staff remain constant throughout the programme in order to build up clients’ trust and feeling of security. It is also better to start with a small project team and to extend the team only when the project is effectively established. The founding team should spend as much time as possible on the street, in order to become known among injecting drug users and sex workers, to promote the project and to gain trust and respect from the clients.

Local networking is important to obtain a good and safe environment for outreach work. Other key stakeholders at the local level (e.g. local government, health and other social services, non-governmental organizations) should be informed about the planned project. In addition, contact with the police about the project’s activities is necessary in order to lobby for their support and for a non-discriminatory approach towards injecting drug users and sex workers.

Recommendations for successful approaches and lessons learned

Recommendations regarding successful approaches and lessons learned reflect the literature review, case studies and discussions at the Vienna meeting. In addition, the general recommendations that follow, some specific recommendations were made in the working groups on this topic at the Vienna meeting. They are summarized in box 12.

- *Involve community members, political leaders, local networks and potential clients in needs assessment, project planning and development.* The case studies described in this section, and the discussions at the Vienna meeting, emphasized the importance of input from a wide range of “stakeholders” such as community and political leaders (both male and female), women with substance use problems and their family members, the police, health and social services and substance abuse treatment networks in

BOX 12

WORKING GROUP RECOMMENDATIONS FOR ENGAGING WOMEN IN TREATMENT

1. Early intervention and engagement into treatment

- Women-only programmes
- Early detection in primary-care settings
- Create awareness and provide realistic and accurate information
- Use motivational engagement strategies that are non-confrontational and non-moralizing and provide flexible programme options

2. Lack of connection to psychiatric treatment to address needs of women with concurrent disorders

- Guidelines for agencies providing substance abuse treatment or treatment for mental health problems
- Integrated rather than fragmented services
- Early recognition of concurrent substance use and mental health problems and intervention needs to increase retention
- Cross-training between substance abuse treatment and mental health systems, as well as health and social services
- Cooperation and networking
- Case management and shared care

3. Addressing cultural traditions

- Community-based services
- Home detoxification
- Adaptation of intervention methods to cultural setting, respecting culture and language
- In some cultures, involve members of the male population in service planning and development in order to overcome stigma and cultural taboos that affect women

4. Taking into account culturally sanctioned substances

- Recognize that alcohol and tobacco are drugs
- Provide information on and education about legal substances
- Modify social use by acknowledging the problems they cause
- Raise awareness that most societal harms come from drinkers who use alcohol socially

5. Poly-substance use among women

- Assess and provide treatment for all substance use problems in one setting
- Incorporate harm-reduction approaches
- Help women set priorities
- Carry out research to determine profiles of women with alcohol or illicit drug problems

- the project planning and development process. Stakeholder involvement provides information for designing the project interventions, including information and understanding of community norms and values. It also contributes to “ownership” of the project and its outcomes. In regions where there are strong cultural taboos about women’s substance use, this process can also help to overcome those taboos.
- *Create a cultural climate of prevention and education.* Because of the stigma surrounding women’s substance use, drug awareness activities that involve all segments of the community can be used as a mechanism for raising awareness about women and substance use and reducing stigma. Both the project in Senegal and the work with Afghan refugee women used this approach. The literature, case studies and discussions at the meeting in Vienna, indicated that awareness materials should provide realistic information appropriate for the audience. In addition to posters and pamphlets, radio, television and films are media that can be used to raise awareness about substances and substance use problems. For women with substance use problems, education about women-specific health issues, including safer sex and safer substance use to prevent the spread of HIV/AIDS and hepatitis, are key components of services to women.
 - *Train/cross-train (shared training) staff in primary-care settings and other health and social service settings.* The literature suggests that women with substance use problems are not being identified in primary-care or other settings, because they are not routinely asked about their use of substances. Training staff in these settings to identify, refer or briefly intervene when substance use problems are identified, can increase the opportunity for women to receive help and broadens the base of treatment. Routine screening was supported as a successful approach at the Vienna meeting. Cross-training or shared training between substance abuse service providers and social or health-care providers can be another means of sharing knowledge and skills, establishing partnerships and collaboration and overcoming negative attitudes towards women with substance use problems.
 - *Reach out to women who are marginalized and hard to contact, as well as women who require more accessible substance abuse treatment services.* The literature and case studies suggest that outreach services can be designed to reach women who are not in contact with any services, as well as women who require services to be brought to them at home or in other settings, such as hospitals or other health-care settings, social agencies or shelters.
 - *Use peer education and outreach to reach women with substance use problems.* The use of peer educators has been supported in the three arms of the project as a strategy to reach particularly marginalized groups of women such as injecting drug users or sex workers. The project in the Islamic Republic of Iran demonstrated the successful use of women who were formerly injecting drug users in reaching and supporting their peers. The role of peers was expanded in the projects in Senegal and work with Afghan refugee women in Pakistan, where women activists in the community were recruited and trained in prevention activities in their communities and in supporting women with substance use problems.
 - *Provide women-only services or women-only components in outreach and low-threshold services.* The literature and case studies indicate that women served by street outreach and low-threshold services are generally extremely vulnerable. They may be homeless, living in a violent or abusive situation, pregnant and living on the street, or engaging in high-risk behaviours such as sharing injecting equipment or having unsafe sex. Women-only services provide the opportunity for women to be in a place of safety from male violence and to receive interventions tailored to their specific needs. Examples include gynaecological care, skills for negotiating safer sex and safer injecting and opportunities to discuss issues such as violence, pregnancy and relationships. Women-only services may also help women overcome the stigma and shame they experience about their substance use.
 - *Use client-centred approaches that respond to women’s priorities and identified needs.* The literature and case studies indicate that women may identify a range of different needs for food, shelter or housing, a place of safety to spend time away from the street, for childcare, for mental or physical health services. Responding to these immediate needs can begin the process of engagement.
 - *Establish cooperation and networking.* Women served by street outreach and low-threshold services are often extremely vulnerable and have multiple and complex needs. They may have had very negative experiences in trying to obtain health or other needed services and have difficulty trusting helping professionals. The literature and case studies demonstrate the need for active networking and the development of partnerships, in order to make appropriate referrals and ensure that women clients will be appropriately received and served. This was also supported by participants at the Vienna meeting.
 - *Encourage policies and activities that promote staff commitment and continuity, and address staff “burnout”.*

Case studies and discussions at the Vienna meeting emphasized that continuity and consistency of outreach workers or staff working in low-threshold settings may be very important to clients. To achieve this, counsellors require ongoing support, supervision and training to encourage continuity, prevent “burnout” and help them deal with the challenging and distressing situations presented by their clients.

Key points

The key points covered in chapter 4 are as follows:

- Involving community stakeholders, both men and women, contributes to community ownership and project success.
- Community projects should be based on a careful assessment of the needs of the target group including an understanding of the cultural norms and values of the community.
- Awareness and education for the whole community can reduce stigma and empower communities to address women’s substance use problems.
- Training primary-care workers and other helping professionals to routinely screen for substance use problems and refer or briefly intervene can lead to improved outcomes, particularly if women are identified at an early stage of problematic substance use.
- Networking and linkages between substance abuse treatment services and services such as prenatal and obstetric/gynaecological services, child welfare/protection services, crises services such as women’s shelters or sexual assault services and mental health (including trauma) services is crucial in providing the array of services and supports that women require. This is particularly important for women who may have had negative experiences in trying to obtain needed services.
- Outreach is an important strategy for reaching women who cannot easily access mainstream services. Outreach can occur in women’s homes, on the street or in any location where women gather. Outreach services need to be tailored to the particular circumstances of the target group. In addition to professionals, peers can be trained to do outreach work and support women in accessing treatment resources.
- Low-threshold services work with a highly vulnerable group of clients who are often injecting drug users at risk of HIV and other blood-borne diseases and involved in the sex trade. Low-threshold services that are gender-responsive provide an opportunity for women to receive harm-reduction services and attention to practical needs, in ways that take into account their specific needs and life circumstances and also provide a place of safety.

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Approaches to engaging women in treatment were outlined in chapter 4. Chapter 5 examines how structured treatment services can be made responsive to women, building on the approaches described in the previous chapter, as well as other publications in the Drug Abuse Treatment Toolkit series of the United Nations Office on Drugs and Crime, particularly *Drug Abuse Treatment and Rehabilitation: a Practical Planning and Implementation Guide* [1]. Their application to planning and developing individual programmes or systems of services for women requires an understanding of factors that influence the development and continuation of women's substance use problems in different sociocultural contexts, as well as adaptation on how substance abuse treatment services are organized and funded in different countries, and the acceptability of different treatment approaches. For example, some cultures do not place the same value on "talking therapies" as they do on pharmacotherapy, which may restrict the use of some of these approaches.

The publication *Drug Abuse Treatment and Rehabilitation* describes the following elements of a comprehensive treatment system: **open access services** (e.g. street-based services or outreach), discussed in the previous chapter; and **structured treatment services**, which include a detoxification-stabilization phase of treatment, a rehabilitation-relapse prevention phase (including pharmacological treatments) and aftercare arrangements. Within structured treatment, there is the option of a non-residential or residential setting.

Following an overview of theory and principles, this chapter presents a discussion on organizational issues, phases of treatment, assessment and treatment planning, psychosocial and pharmacological treatment interventions and special needs of pregnant and parenting women.

As defined earlier, gender-responsive treatment refers to programmes that consider the needs of women in all aspects of their design and delivery. An inventory of what is meant by gender-responsive is given in box 13. Some services will be able to incorporate many aspects of this inventory in their programming, while others will want to develop priorities regarding the aspects they can reasonably incorporate that are consistent with their circumstances and resources.

Theory and principles

Though programmes may be eclectic in the types of counselling methods they employ, a unifying theory and set of principles provides a framework for programme development, programme content and programme materials. They ensure that staff "all convey the same message to clients, and base their treatment on shared philosophical beliefs and values about the treatment of women" [4].

Recent approaches to women's substance abuse treatment have been influenced by theories of women's psychological development, and recognition of the central role that relationships and connection to others play in women's sense of self; the importance of using counselling methods that empower and strengthen women; and the need to recognize and address women's experience of trauma. One example of gender-responsive principles is shown in box 14. The case studies included in this chapter illustrate the practical application of these principles.

Programme organization

In planning and implementing substance abuse treatment services for women, decisions will need to be made about a number of organizational issues. The extent to which these issues can be addressed will depend on the context in which the programme is being developed and available resources.

BOX 13

WHAT IS MEANT BY “GENDER-RESPONSIVE”

“Gender-responsive” implies [2, 3]:

- A safe, supportive and woman-nurturing environment that encourages trust, bonding and connection;
- Theoretical perspectives that incorporate women’s life experiences and reality;
- Programme approaches based on theories that fit the psychological and social needs of women;
- Therapeutic modalities or approaches (e.g. relational) that address issues such as physical, sexual and emotional abuse, family relationships, substance abuse, eating disorders and other concurrent disorders;
- Opportunities to develop skills in a range of educational and vocational areas (including non-traditional vocational skills);
- A strength- or asset-based approach to treatment and skill-building and an emphasis on activities that focus on empowerment and self-efficacy;
- Staff that reflect the client population, in terms of gender, race or ethnicity, language and recovery status;
- Female role models and mentors that reflect the racial or ethnic and cultural backgrounds of the clients;
- Utilization of gender-responsive assessment tools, and individualized treatment plans that match appropriate treatment with the identified needs or assets of each client;
- Education and counselling relating to health (e.g. pregnancy, nutrition, stress management, HIV/AIDS, hepatitis, sexually transmitted diseases) and mental health (e.g. post-traumatic stress disorder, depression);
- Emphasis on parenting education, child development and relationships (or reunification) with children (if relevant);
- Child-friendly environment with age-appropriate activities designed for children and childcare on site for residential services;
- Linkages to community-based agencies for drug-free supportive housing, employment, substance abuse treatment, mutual aid groups, child welfare, domestic violence, parenting, childcare, peer support groups, health, mental health, HIV/AIDS, day treatment and aftercare;
- Gender-responsive and culturally competent in-service staff training.

BOX 14

GUIDING PRINCIPLES FOR GENDER-RESPONSIVE TREATMENT

Gender: Acknowledge that gender makes a difference.

Environment: Create an environment based on safety, respect and dignity.

Relationships: Develop policies, practices and programmes that are relational and promote healthy connections to children, family, significant others and the community.

Services: Address the issues of substance abuse, trauma and mental health through comprehensive, integrated, culturally relevant services.

Economic and social status: Provide women with opportunities to improve their socio-economic conditions.

Community: Establish a system of community care with comprehensive, collaborative services [5].

Programme structure

Options for providing gender-responsive programming for women include:

- A women-specific programme that is autonomous with its own governance structures (board of directors);

- A women-specific programme that is part of a larger organization; or
- A programme that serves both women and men but has some components for women only.

The projects described in this publication illustrate all of these administrative structures. Programmes may also

wish to consider the representation of women in governance and management structures, depending on the cultural context in which the programme is being developed. For example, autonomous women-only services may wish to ensure that women play a leadership role in governance and have agency by-laws that require that the majority of board members be women and/or that certain board positions are filled by women.

Regardless of structure, programmes may also want to consider policies that require that some management positions are restricted to women. Women in leadership positions can be role models for women clients. Programmes that are part of a larger administrative structure could consider a programme advisory committee. A programme advisory committee can be a voice from the community to promote the need for and continuation of women's services, as well as playing a networking function with other community agencies and stakeholders. Both boards of directors and programme advisory committees provide an opportunity for women who are graduates of the programme to have a continuing role in the development and evaluation of the programme.

Addressing safety issues

Safety is an issue for all women, but particularly for women who have been physically or sexually abused. Unfortunately, based on the literature, some women report that they have been harassed in mixed-treatment settings [6].

The following are suggestions for making the environment safe:

- Provide privacy in mixed-gender programmes with structures that separate women from men, such as separate entrances, living and sleeping areas and programming rooms;
- Have female staff on all shifts;
- Maximize the safety of the external environment with adequate lighting and an open environment (not lots of dark trees and bushes) and close proximity to transportation routes for non-residential programmes;
- Ensure that outreach to women on the street does not put them at risk of harassment from their male sex partners or other men in their lives who might pose a threat;
- Put in place programme policies and a programme culture that do not allow physical or sexual harassment of women by male staff or male clients.

Staffing

In situations where programmes have adequate resources, some that serve only women will in principle only hire women staff; others will choose to have both male and female staff. Discussions at the meeting of the United Nations Office on Drugs and Crime entitled "Women's Drug Treatment: Lessons Learned", held in Vienna from 15 to 17 December 2003, indicated that where choice and resources were available, the involvement of male staff needed to be carefully thought through in terms of their role in women's treatment. For example, the use of male staff may be more appropriate in later phases of women's treatment, or as co-therapists for educational groups or family therapy sessions. Clinical experience does not support the use of male staff as co-therapists for women's issues or trauma groups. It should also be noted that a number of studies have reported that women with a female primary therapist were less likely to engage in "risky" substance use six months following treatment than were women with a male therapist [7, 8].

Preferably, women should be provided with a choice as to whether they have female or male counsellors for individual counselling. However, as some of the case studies demonstrate, during the early phases of programme development, trained female staff may not be available. In such situations, there may need to be close supervision of male staff working with female clients to ensure that a professional counselling relationship is maintained. The following should also be considered:

- Some women, especially those with a history of abuse, see other women as competition, so female staff should model appropriate, non-competitive relationships, and programmes should promote a model of staff and client relationships based on equality rather than power and hierarchy.
- If resources allow, staff with a mixture of professional training and skills to address multiple client issues, such as relationships, parenting, child custody and mental and physical health, should be employed.
- A proportion of the staff should be able to share some characteristics with clients (e.g. language, culture, age, recovery from substance use problems) and serve as positive role models. Peer counsellors can play an effective role, but they may need additional supervision and support.

Some important characteristics of staff as perceived by clients are illustrated in box 15.

BOX 15

STAFF CHARACTERISTICS PERCEIVED BY CLIENTS

Nelson-Zlupko and others [6] interviewed women in recovery regarding their perceptions of treatment. While participants indicated the desire for a choice of counsellor in terms of her or his demographic characteristics, a key theme was the importance of basic respect from the counsellor. According to another study of seven women's substance abuse treatment programmes regarding staff characteristics that were most helpful, the availability of staff to "be there" for clients and listen to their concerns and problems confirmed the importance of staff who could make clients feel cared for, respected and understood, and this played a key role in client retention [9].

women such as eating disorders, anxiety and depression, and social phobia;

- Suicide prevention;
- Sexuality.

There may also be special competencies or training needs related to particular groups of women, such as women who are involved with the criminal justice system, women who have a disability, lesbian women, women who are homeless or live on the streets, and women from cultures different from the dominant culture. The competencies or training needs listed above reflect societies that are generally well-resourced. Where there are fewer resources, there may be other options to provide these competencies, such as through seconded staff, shared training or close linkages with other agencies that can offer resources.

Competency, training and supervision

Having appropriately trained and competent staff is an important factor in providing services that are responsive to women's needs, though the type of knowledge and skills may vary between cultures and countries, as well as between different types and levels of service. Though much of the competencies or training of staff working in substance abuse treatment will enable them to work with either gender, there are some that are more specific to women. These include:

- Knowledge about women's life circumstances, the development, consequences and continuation of substance use problems;
- The relational area of women's lives;
- The impact of trauma on women's lives and how it affects them;
- Gender issues related to reducing high-risk behaviours (safer injecting, safer sexual practices);
- Gender issues related to women's health, including HIV, hepatitis and other infectious diseases;
- Knowledge of local resources and their appropriateness for women, particularly in relation to domestic violence and safety issues.

Other areas include:

- Issues related to children such as parenting skills and child welfare;
- Post-traumatic stress disorder and other concurrent disorders, particularly disorders more common among

Providing staff supervision that enhances the quality of care and staff satisfaction and prevents staff "burnout" is clearly not a function unique to women's programmes. However, there may be counselling situations more typical in services for women that are difficult and stressful for counselling staff to handle, and that may present ethical issues. Examples include addressing child welfare and child protection issues, counselling pregnant women who continue to use substances and engage in high-risk behaviours, counselling clients in abusive relationships, providing counselling for trauma and addressing inappropriate relationships between male staff and female clients.

Needs assessment and programme monitoring and evaluation

Much less is known about the characteristics and treatment experiences of women than those of men. This may be particularly true in countries with strong taboos about women's use of substances. Projects can contribute to the pool of knowledge about women with substance use problems when programme planning and development are based on a systematic assessment of needs and programmes put in place procedures for ongoing monitoring of programme and client objectives and outcomes. As illustrated in a number of the case studies, the involvement of women with substance use problems as key informants during the needs assessment phase and contributing as clients to programme monitoring and evaluation activities ensures that the programme will continue to be relevant to the women it serves.

Structured treatment services

Treatment settings

Withdrawal from substances may take place in a hospital, a community residential service or an outpatient or non-residential setting, depending on factors such as the client's circumstances, the severity of the substance use problem and the history of withdrawal problems. In some regions, non-residential or home detoxification services are not available or appropriate. However, residential detoxification services may present access barriers for women with children. Case studies described later in this chapter provide examples of services that have addressed the need for childcare for women using detoxification services, such as at Jarrah House and Sahara House.

While residential treatment for the relapse-prevention phase of treatment is common in many parts of the world, it can also present a barrier for women who have family or household responsibilities or who do not have the financial resources to pay for the costs of treatment, childcare and transportation to the programme facility. However, some women require the 24-hour monitoring and support provided in a residential setting because of the severity of their substance use and associated problems and the lack of sufficient support and resources to manage in an outpatient setting. Some women may also require a residential setting to escape their current circumstances, which may involve domestic violence, living in a substance-using environment or homelessness.

BOX 16

EXAMPLES OF OUTPATIENT SERVICE PROVISION

- Individual and group counselling
- Separate women's groups with a female therapist (as part of a mixed-gender outpatient setting)
- Variety of treatment modalities, including feminist-informed social therapy
- Comprehensive assessment for treatment planning and care, including medical and psychosocial treatment needs, abuse history, children-related issues
- Continuous care, visiting clients in prisons, hospitals and at home
- Long-term case management, including referrals to other levels of substance abuse treatment and other needed services
- Methadone maintenance treatment [10]

Community-based outpatient or day treatment provides a more accessible and lower-cost treatment option for women who have sufficient supports to manage between treatment sessions. In box 16 the types of services provided in outpatient treatment are described, as identified in the report entitled *Problem Drug Use by Women: Focus on Community-Based Interventions* [10].

Outpatient treatment settings can offer the following advantages:

- Less intrusive (disruptive to women's lives) than residential treatment;
- Can be offered in a variety of settings that need not necessarily be substance abuse-specific and may be less stigmatizing to women (e.g. in social agencies, women's services or other settings close to where women live);
- Can use a mobile format and be offered in different locations and/or communities on a rotational basis;
- Less costly than residential treatment;
- Opportunity for flexible programme scheduling (day/evening/weekend);
- In mixed-gender settings, women-only outpatient groups can be offered continuously where numbers allow, or on a rotational basis where numbers of women are smaller; and
- Easier to provide childcare.

Outpatient treatment is also described in the publication *Intensive Outpatient Treatment for Alcohol and Other Drug Abuse* of the United States Center for Substance Abuse Treatment [11].

Duration of treatment

Duration of treatment research indicates that longer lengths of stay and/or more frequent treatment contacts (e.g. three or four outpatient sessions a week rather than one or two) are associated with better treatment outcomes [12]. Experts who contributed to the report of Health Canada entitled *Best Practices: Treatment and Rehabilitation for Women with Substance Use Problems* [13] recommend that residential treatment should not be less than four weeks in length and outpatient treatment 3-6 months, but with flexibility based on the individual client's need rather than rigid standardization. The United States National Institute of Drug Abuse publication entitled *Principles of Drug Addiction Treatment: a Research-Based Guide* [14] notes that, for most people in treatment, the threshold of significant improvement is reached at about three months in treatment.

Aftercare or continuing care

Aftercare or continuing care is an important component of ongoing support to clients and may be crucial to clients completing an intensive residential programme who are returning to their communities. Aftercare can be provided in a number of ways, individual or group format, face-to-face or by telephone, regularly scheduled sessions, or drop-in, as needed. In countries where Alcoholics Anonymous, Narcotics Anonymous or other mutual aid groups are available, they can play an important and ongoing role in providing clients with support in their recovery. The case study describing work with women's associations in Senegal demonstrates an innovative approach to providing aftercare using women peers in the community supported by treatment professionals visiting on an "as-needed" basis (see chapter 4).

Social reintegration activities

Social reintegration activities are part of the aftercare phase. As noted in a recent report of the European Monitoring Centre for Drugs and Drug Addiction [15], the focus of social reintegration is on training, education and the development of skills; employment; and housing. Research has supported the need for attention to be given to these practical issues for women, and several of the projects described in this publication include social reintegration components, particularly the development of employment skills, promoting income-generating projects and providing transitional housing. Securing stable housing is often a key focus for women wishing to regain custody of their children. Close linkages with services that can address education and skills development or housing may be required. In addition, help may be needed in this phase of recovery to develop skills to make new friendships and access recreational activities that provide alternatives to substance use.

Stepped care

Well-integrated treatment systems, or individual treatment services that are able to offer a full continuum of care, provide the option of a "stepped approach" to treatment. This allows clients to make the transition to a less or to a more intensive treatment setting as their needs change. Several of the case studies included in this chapter, such as the Programa de Atenção à Mulher Dependente Química (PROMUD) of Brazil and Marin Services for Women, provide examples of multi-component services.

Assessment and treatment planning

Assessment

A comprehensive assessment ensures the development of a client-centred treatment plan, providing an opportunity to explore patterns of substance use and related problems, strengths and concerns, readiness for change, and barriers that may prevent a woman from entering and remaining in treatment. A comprehensive assessment results in a treatment plan that is consistent with a person's treatment goals and treatment choices. Assessment is not a one-time event, but a process that should be repeated during the course of treatment to monitor change and determine readiness to move to a less intensive phase of treatment or, alternatively, to increase treatment contact and support. Information gathered during an assessment can also contribute to programme monitoring and evaluation activities.

A wide variety of assessment instruments are available, but most are not specific to women. The European Monitoring Centre on Drugs and Drug Abuse has a databank of instruments that can be used for assessment, as well as to track clients for evaluation purposes. However, these tools would need to be verified for use with women in different cultures and countries.

A commonly used instrument is the Addiction Severity Index (ASI), which has been translated into a number of languages, including Farsi, and a version is included in the publication *Drug Abuse Treatment and Rehabilitation: a Practical Planning and Implementation Guide* [1]. ASI has also been modified by the University of Washington for pregnant and postpartum women [16]. An expanded version of ASI, the Expanded Female Version of the Addiction Severity Index, has also been developed, it includes questions specifically relevant to women [17].

The Psychosocial History [18] is also a supplemented version of ASI, developed specifically for use with pregnant and parenting women using substances. It is described in the publication of the National Institute on Drug Abuse entitled *Treatment for Drug Exposed Women and Their Children: Advances in Research Methodology*.

Some additional assessment instruments appropriate for women, including methods for assessing exposure to trauma, post-traumatic stress disorder and concurrent disorders are described in the United States Center for Substance Abuse Treatment publication entitled *Substance Abuse Treatment: Addressing the Specific Needs of Women* [19]. The following areas were identified in chapter 1 under gender differences and should be con-

sidered as part of a comprehensive assessment, recognizing that issues may differ depending on the cultural and societal context:

- Current relationships and, in particular, substance use by a partner and other family members or people with whom the client is living;
- Pregnancy;
- Family responsibilities, including care of dependent children or older relatives, and parenting issues related to the physical and mental health of the client's children;
- History of physical or sexual abuse or other trauma, particularly self-identified need for sexual assault support services;
- Mental health status, particularly anxiety and depression, post-traumatic stress disorder, eating disorders and phobias;
- Suicide risk and other self-injurious behaviour;
- HIV and hepatitis risk behaviours (sharing injecting equipment, unprotected sex);
- Current domestic violence and/or unsafe living situation;
- Education, employment, financial situation, housing;
- Risk of serious withdrawal symptoms;
- Perceived barriers to engaging and remaining in treatment, such as family responsibilities, lack of family support, financial constraints and difficulties with transportation to treatment.

The assessment may be the first time the client has had an opportunity to discuss her substance use and related problems with someone who is non-judgemental and accepting. However, counsellors should be cautious in asking about some issues, particularly experiences of trauma, unless they have received training on how to safely and appropriately explore these issues with clients and can assist clients in dealing with distressing symptoms that may be triggered by assessment questions.

Treatment goals

Though the severity of a woman's substance use and related problems may make abstinence the preferred treatment goal, some women may not see their substance use as a priority or may not feel they have the resources to stop substance use at that time. Unfortunately programmes tend to focus on either abstinence or harm reduction. This can limit the number of women who can be reached and helped by treatment services. A recommendation would

be to provide services on a continuum that includes harm reduction with abstinence at one end of the continuum, since, for many women with severe substance use problems, abstinence is necessary for recovery.

Offering harm reduction approaches encourages clients to set achievable goals to improve their health, even if they do not give initial priority to their substance use. It also allows women to maintain contact with helping services and experience successful change. In the longer term, women may be ready to consider working towards abstinence goals. Though harm reduction options are most often offered through low-threshold or outpatient services, more intensive services can also support harm reduction approaches by taking a flexible and supportive approach to client relapse; providing information and education about safer injecting practices, safer sex and the availability of sterile needles/syringes and condoms; providing information about HIV, hepatitis C virus and other blood-borne diseases and referral for counselling and testing; referring and supporting clients in exploring opioid maintenance treatment; and educating staff about harm reduction approaches.

Treatment placement criteria

A number of jurisdictions have developed standardized client/patient placement criteria in order to match individuals to the appropriate level and intensity of treatment. Though these have not been developed specifically for women, they nevertheless provide some guidelines to consider. In North America, most are based on the original American Society of Addiction Medicine guidelines [20]. Placement criteria recognize that no one approach is suitable for every client and that, all things being equal, the treatment level/intensity selected should be the one that will be least intrusive in terms of disrupting the client's life. This is particularly important for women, who often find it difficult to participate in residential treatment because of their childcare and other family responsibilities, as well as cultural norms in some societies that make it difficult for women to leave home. Placement criteria, together with ongoing assessment information, also provide a basis for determining when the client is ready to be discharged from treatment or move to a less intensive treatment setting.

Case management/care coordination

The concept of case management or care coordination is also described in the publication *Drug Abuse Treatment and Rehabilitation: a Practical Planning and Implementation Guide* [1]. It is a function that can involve client

assessment and treatment planning, linking with required services, advocacy to ensure client access to required services, and monitoring and support. It is particularly applicable to women who often need multiple health and social services and, in addition, have often had poor experiences in trying to obtain needed services. As an example, studies reported in the literature indicate that the use of trained paraprofessional case managers has resulted in positive outcomes for pregnant women in the areas of substance use problems, family planning and social reintegration [21, 22]. In areas where comprehensive substance abuse treatment services are not available, a case manager can advocate and link clients with available health and social services. The case management function can be done either by a specialized substance abuse treatment service or by another service.

Psychosocial interventions

Introduction

To address the needs of women with substance use problems, a range of therapeutic approaches and treatment components are required. This is illustrated by many of

the case studies described in this chapter whose programmes employ a variety of modalities and approaches, including individual and group counselling modalities, a combination of cognitive-behavioural and psychodynamic approaches, skill development and attention to practical needs.

Comprehensive or enhanced programming

Studies suggest that treatment-seeking women, when compared with men, have more severe problems, including a history of trauma and concurrent mental health problems, fewer resources in terms of employment and income, fewer social supports for treatment and greater family or household responsibilities.

Clinicians working with women have been aware for a long time of these multiple and complex needs and have developed innovative programmes to address them. However, research has lagged behind clinical innovation, and it is only recently that research has begun to support the effectiveness of enriched or comprehensive treatment for women. Recent research, described in more detail below (see box 17), indicates improved outcomes in programmes that respond to women's specific needs.

BOX 17

RESEARCH STUDIES ON OUTCOMES FOR WOMEN PARTICIPATING IN PROGRAMMES THAT RESPOND TO WOMEN'S SPECIFIC NEEDS

A meta-analysis of 33 women's substance abuse treatment programmes by Orwin and colleagues concluded that enriching women's treatment with additional components specifically oriented toward meeting women's needs, adds value above and beyond the expected effects of standard, women-only programmes [23]. Enhancements that were identified in this meta-analysis included childcare services, parenting training, women-only therapy groups, self-esteem and assertiveness training, and education about sexuality and family planning.

Similarly, a review of 38 treatment outcome studies (7 randomized controlled trials and 31 non-randomized studies) on the effectiveness of substance abuse treatment programming for women by Ashley and colleagues [24] found improved treatment outcomes, such as increased retention rates, decreased substance use, improved perinatal and birth outcomes (programmes serving pregnant substance using women) and improvements in HIV risk behaviours, self-esteem and depression were associated with the following components: childcare, prenatal care, women-only admission, supplemental services and workshops that addressed topics focusing on women, mental health programming and comprehensive programming.

Another recent review of psychosocial treatments for women with substance use disorders [25] concluded that, while there was little evidence supporting poorer outcomes for women than men, with the possible exception of employment outcomes, there is some evidence that women benefit from enhanced treatment services, including childcare, parenting classes and individual therapy. They also suggest that men who share some characteristics of women (e.g. primary caregivers for dependent children or trauma victims) may also benefit from enhanced services.

An Australian study comparing a women-only service with a traditional mixed-sex treatment service found that the former was significantly more likely to attract women who had dependent children, lesbian women, women who had a maternal history of drug or alcohol problems and women who had experienced sexual abuse in childhood. These results suggest that gender-sensitive treatment services may be recruiting women who might not otherwise have sought treatment for their substance abuse problems [8, 26]. In addition, for lesbian women, women with a history of sexual assault in childhood and those with dependent children, attendance at a specialist women's service reduced the incidence of treatment drop-out [27].

The studies discussed in chapter 1 indicated that women with substance use problems generally have fewer resources in terms of education, employment and income. Some women may be living in conditions of extreme distress and struggling to manage daily survival for themselves and their families. These situations may be exacerbated for women who live in societies where they have little power to change their life circumstances. Thus, research has also supported the need for access to food, clothing, shelter, transportation, education, employment/income-generation opportunities, legal assistance, medical care, social services and social support and family therapy. In some societies, strategies to address these needs may be linked to more general strategies for empowering women. Linking women with resources outside the treatment setting may also be necessary; for example, resources help women improve their literacy skills or develop skills needed for income generation or for gaining access to reproductive care.

A study by Nelson-Zlupko and others [6] on client perceptions of treatment, in box 18, described, supports the need for comprehensive services.

Cognitive behavioural treatment modalities

Cognitive behavioural treatment modalities, based on learning theory, are designed to help individuals change negative thoughts or beliefs that lead to harmful behaviour and to acquire new behaviours or coping skills. Cognitive behavioural treatment interventions are usually structured and practical, involving the client in activities such as setting goals, monitoring substance use and its immediate antecedents and consequences,

identifying and practising new coping skills to avoid relapse to substance use and acquiring techniques or skills, for example, to replace negative thoughts or beliefs with positive ones, solve problems, reduce stress or interact socially.

Cognitive behavioural treatment modalities have received considerable support in the scientific literature when tested with treatment samples that have included women. In addition, they have been supported by treatment experts as an effective treatment modality for women. In most circumstances, cognitive behavioural treatments should be complemented by other approaches such as relational work and attention to mental health issues, as well as giving attention to practical needs. Examples of cognitive behavioural treatment modalities that have received support in the scientific literature include contingency management; behavioural marital therapy; skills training, including relapse prevention; community reinforcement approaches; and stress management. Some research studies have examined the application of cognitive behavioural approaches to specific groups of women; for example, contingency management has been shown to be effective in increasing attendance and abstinence from illicit substances among pregnant women receiving methadone maintenance treatment.

As with other approaches, cognitive behavioural treatments may need to be adapted to the circumstances of the client group. As one example, there is evidence that men and women relapse for different reasons, and women are more likely to relapse in situations where they are experiencing negative emotions or interpersonal

BOX 18

CLIENT PERCEPTIONS OF TREATMENT

Client feedback provides an important mechanism for determining the type of programming that is helpful to women. Women's perceptions of treatment effectiveness and helpfulness have been studied by Nelson-Zlupko and others [6]. They interviewed 24 women who had received specialized and non-specialized substance abuse treatment. Although the findings from this study cannot necessarily be generalized to women in other contexts or countries, they are consistent with findings emerging from the literature about effective treatment. Services that were endorsed by 75 per cent or more of the women interviewed as being helpful or very helpful included: transportation assistance (86 per cent), help obtaining food, housing, clothing, etc. (83 per cent), recreational activities (83 per cent), on-site health care (82 per cent), 12-step meetings (81 per cent), discussion of women's issues (80 per cent), medication (76 per cent), emergency financial assistance (76 per cent), women-only groups (75 per cent) and reproductive health education (75 per cent). Least helpful were co-ed groups (6 per cent). This same study also identified a number of themes emerging from the interviews with the women. Individual counselling was the most important feature of substance abuse treatment (someone to be there for them); sexual harassment from male counsellors can occur in conventional treatment programmes; childcare is central to the recovery of women with children; most co-ed treatment groups fail to provide a forum for open expression of women's needs and experiences; and the effectiveness of gender-sensitive services is diminished in treatment settings that fail to support and promote women [6].

conflict. Behavioural relapse prevention interventions should be designed to reflect these differences.

The National Institute of Drug Abuse of the United States has published a series of behavioural therapy manuals based on empirically supported treatments (www.nida.nih.gov/DrugPages/Treatment.html).

Stages of change model and motivational interviewing

The “stages of change model” developed by Prochaska and DiClemente [28] recognizes that people are at different stages of readiness to change their behaviours, and counsellors should use strategies and interventions that are appropriate to the client’s stage of change. Motivational interviewing is a client-centred counselling approach developed by Miller and Rollnick. They have defined motivational interviewing as a directive, client-centred counselling style for eliciting behaviour change by helping clients to explore and resolve ambivalence [29].

The motivational interviewing approach contrasts with confrontational approaches that have been used in the past to induce behaviour change and were believed by many clinicians to be particularly damaging for women with substance use problems, who often suffer from low self-esteem, anxiety or depression. Motivational enhancement therapy is a brief treatment designed to increase motivation for change by applying the principles and techniques of motivational interviewing. It has been found to be effective with opioid-dependent individuals. Motivational interviewing approaches are described in a publication by the Center for Substance Abuse [30] and on the Internet (www.motivationalinterviewing.org).

Women with substance use problems often have other complex and urgent problems that need to be taken into account in treatment planning. Brown and colleagues [31] have extended the stages of change model into what they describe as women’s steps of change, as described in box 19.

Relational theory

Relational theory arises from the work of Jean Baker Miller, who identified women’s primary motivation as the need to build a sense of connection with others and noted that a woman’s sense of self and her self-worth were based on this connectedness—women carry responsibility for the care and maintenance of relationships, and this model attempts to articulate the strengths as well

BOX 19

WOMEN’S STEPS OF CHANGE MODEL

Research has extended the stages of the change model into what is described as a “Women’s Steps of Change” model, which encompasses four life areas in which women may be ready to change: domestic violence, sexual risk behaviours, substance abuse behaviours and emotional problems [31]. Brown and her colleagues propose that the help-seeking behaviour of women with substance use problems may reflect a hierarchy of readiness to change based on the urgency or immediacy of their treatment issues. For example, their study suggests that some women may be ready to make changes in their exposure to domestic violence or in sexual risk-taking behaviour before they are ready to change their substance use behaviour.

as the problems arising for women from the relational orientation [32]. This is in contrast to traditional theories of psychological development that identify separation and individuation with psychological maturity. As described by Finkelstein and others [33], relationships or loss of relationships play a central role in women’s use of substances. Many women with substance use problems have relationships that have been characterized by abuse, violence and substance use. Women may use substances to maintain these relationships (e.g. with a substance-using partner); to fill the void left by unsatisfactory or failed relationships; or to deal with the pain of abusive relationships. Traditional individual treatment approaches would often strive to disconnect women from these relationships, whose maintenance was often critical to women’s self-esteem. The result was frequently treatment dropout, as women returned to their partners, families or children and thus would be viewed as sabotaging their treatment.

Incorporation of relational theory into women’s treatment interventions recognizes that making and maintaining relationships play a central role in women’s lives and that disconnection from relationships can result in low self-esteem or other negative emotions. It also recognizes the importance of women’s connections to their children; and the role that positive social support can play in women’s recovery from substance use problems. Treatment programmes for women should incorporate programme components and materials that allow women to look at their past and current relationships, and to learn ways to develop and maintain healthy relationships. Relational theory and its application to women’s substance abuse treatment are described in more detail

in other publications [4, 19, 32, 33, 34, 35]. Modules and tools for helping women explore their relationships are discussed by Najavits [36].

In addition to specific programme components and time devoted to having women work on relationship issues, partner or family education, family therapy, on-site childcare or ensuring that space is available for family visiting, parenting skills and group therapy are different ways that programmes can acknowledge and support women's network of relationships.

Relational theory and its incorporation into treatment for women contrast with the view, popular in the 1980s, of women, and of other family members of an individual with a substance use problem, as being co-dependent. Co-dependent family members were seen as being part of the problem and in need of treatment to help them change their dysfunctional relationships and coping skills. In particular, women's "caretaking" role was viewed as a negative rather than a positive attribute.

Group therapy

Group therapy can support women in developing a connection to other women. Some studies have shown that women engage in group therapy more often than men, but studies have also found that mixed-gender groups are less effective for them than women-only groups. This makes sense, as women are usually a minority in mixed-gender groups, and they may be less likely to get their issues addressed because men and women have different styles of interacting. Men generally dominate group interactions and interrupt more often, while women defer to male group members and, in some cases, compete with each other for male attention. Women with past or current abuse issues may feel particularly vulnerable in mixed-gender groups.

In areas where only a few women enter treatment and there are insufficient numbers to offer separate women's groups, programmers may want to consider policies regarding the inclusion of women in mixed-gender groups. For example:

- Integrating women into a group with men only when their numbers reach a certain proportion of the group, such as 30 per cent, to ensure that a woman is not alone in a group;
- Having a male therapist and a female therapist co-facilitate in mixed-gender groups; or
- Providing individual support to women in the absence of an appropriate group.

Concurrent mental health problems

Concurrent mental health problems, particularly anxiety and depression, post-traumatic stress disorder, eating disorders (especially bulimia and bulimic behaviours), phobias and some personality disorders (e.g. borderline personality disorder), are generally more common among women with substance use problems than among men. Counselling staff need to screen for the presence of mental health problems and, if resources are available, refer for proper assessment, diagnosis and specialized treatment. Counsellors also need to be aware that the effects of substance use (during both use and withdrawal) can mimic the symptoms of some psychiatric disorders, making it difficult to determine whether there is an underlying mental health problem or whether the symptoms are drug-induced. A period of abstinence can help resolve this issue. In addition, using even small amounts of a substance can make some mental health problems worse. Cultural norms, including gender norms, also influence the likelihood of being diagnosed with a particular psychiatric disorder.

Women with substance use and mental health problems often do not receive appropriate help. Their substance use problem may not be identified and addressed by the mental health system, and mental health problems may not be addressed by the substance abuse system. Studies indicate that having a concurrent substance use and mental health disorder is associated with poorer treatment retention rates and treatment outcome.

To improve this situation, recent guidelines [37] on treatment for individuals with concurrent substance use and mental health disorders recommend that both disorders are addressed through an integrated treatment plan, whether the actual interventions occur concurrently or sequentially and whether treatment is provided within one programme or through collaboration between different programmes. Research is under way on integrated treatments for psychiatric disorders common among women with substance use problems, including post-traumatic stress disorder and borderline personality disorder [36, 38, 39].

In programmes dealing with women with substance use problems, attention should also be given to the fact that many women will have experienced at least one traumatic event in their lives and be at risk of developing a post-traumatic stress disorder or another mood or anxiety disorder (which may be concurrent with post-traumatic stress disorder) if trauma issues remain unresolved. Substance use may increase following the traumatic experience or substances may be used to self-medicate

the symptoms of a post-traumatic stress disorder. If the individual stops using substances, post-traumatic stress disorder symptoms may recur or increase, precipitating relapse and possibly treatment drop-out. Substance use may also make women more vulnerable to re-victimization and re-traumatization.

Post-traumatic stress disorder (PTSD) occurs as a result of experiencing a traumatic event or events that involve actual or threatened death or serious injury to the individual or others, including sexual abuse, in which the person experienced intense fear, helplessness and horror. Three clusters of symptoms define PTSD:

- *Re-experiencing the event* through flashbacks, nightmares or physiological responses brought on by the memories;
- *Avoidance of people or things that might trigger recurrence of intrusive thoughts about the event*, which can include emotional numbing, depersonalization and withdrawal;
- *Hyper-arousal* such as increased vigilance, startle response or heightened aggression, as well as difficulty sleeping or concentrating.

The literature indicates that rates of reported physical and sexual abuse, particularly childhood sexual abuse, and PTSD are higher among women than among men with substance abuse problems. Though much of the recent research literature on trauma, PTSD and substance use problems relates to the experience of physical or sexual abuse, some clients will have been severely traumatized through exposure to conflict and war. This was the case for some of the Afghan women described in the case study in chapter 4.

Addressing women's experience of trauma is increasingly considered a key aspect of providing gender-responsive services. It is critical that services for women are able to create a safe environment, and provide affected women with the skills to deal with the immediate symptoms of trauma and PTSD. At the same time, programmes should be cautiously structured in their approach to dealing with trauma, since the literature indicates that when untrained staff attempt to address childhood sexual abuse issues and encourage women to dwell on painful emotions without support, relapse is more likely to occur than when the issue is not addressed at all [8].

Though most substance abuse treatment services will not have the expertise and resources to provide specialized trauma counselling or interventions for PTSD, they

will be more effective if they are "trauma-informed". Trauma-informed services are services that are knowledgeable about violence against women and the impact of trauma. Trauma-informed services:

- Recognize that their clients may have experienced trauma and the connection to substance abuse;
- Avoid triggering trauma reactions and/or traumatizing the individual;
- Adjust the behaviour of counsellors, other staff and the organization to support the individual's coping capacity;
- Allow survivors to manage their trauma symptoms successfully by providing information/education so that they are able to benefit from substance abuse treatment.

In discussions at the Vienna meeting, it was suggested that in situations where staff are not trained, and a client discloses trauma, staff should be empathetic and use basic counselling skills, reflective listening and reassurance, to validate the client's experiences. (See Covington [3], Finkelstein [40] and Hiebert-Murphy and Loytkiw [41] for resources on addressing trauma and substance use problems.)

Smoking cessation

Smoking is both an organizational and a therapeutic issue. Rates of concurrent tobacco use among those who use other substances harmfully are very high. In addition, according to the World Health Organization, while the smoking epidemic is declining among males, rates among women will not reach their peak until well into the twenty-first century unless there are major changes in prevention and cessation rates. Smokers have elevated rates of serious health problems and premature death compared with non-smokers, and there is evidence that women may be more vulnerable than men to tobacco-related health consequences. About one in five pregnant women smoke, and smoking during pregnancy can be detrimental to the foetus. At the same time, evidence is emerging that smoking cessation policies and programmes can safely be included with treatment for other substances. Supporting women in their efforts to quit smoking may be all the more crucial, since studies indicate that women have more difficulty quitting smoking than men. Quitting smoking may reduce the risk of relapse and increase the chances of recovery. Policies and practices that could be considered by programmes include:

- Putting in place smoke-free policies and procedures in the programme areas;
- Tobacco-use assessment as part of an overall assessment of substance use;
- Providing information and education about the health-related consequences of smoking;
- Offering women smoking-cessation programmes in-house or through referral.

Effective interventions include behavioural group therapy and nicotine replacement therapy, though the latter has not been evaluated in pregnant women [42].

Pharmacological interventions

Medications used in the treatment of substance dependency work in different ways. Agonistic medications belong to the same class as the problem substance but have a longer duration of action. Agonists can relieve withdrawal and craving symptoms; for example, methadone is used to treat dependence on heroin or other opioids. Antagonist medications block the reinforcing effects (euphoria) of the problem substance; for example, Naltrexone is used for opioid dependence. Buprenorphine is a partial agonist in that it can produce both agonist and antagonist effects. In aversive therapy, the medication produces an unpleasant reaction if the problem substance is used at the same time, for example if the client drinks when taking disulfiram (Antabuse®).

Opioid dependence

Opioid substitution treatment has received extensive support in the scientific literature as an effective pharmacological treatment to reduce illicit substance use and associated problems, such as transmission of HIV and hepatitis, overdose deaths and criminal activity, and to improve life functioning. Substitution treatment is the treatment of choice for pregnant women. The most commonly used substitution drugs for the pharmacological treatment of opioid dependence are methadone and buprenorphine. These drugs can also be used for detoxification, though relapse rates following detoxification alone are high, unless followed by psychosocial treatment. Naltrexone, slow-release morphine and codeine are also used in some countries for the treatment of opioid dependence. Levoalphacetylmethadol (LAAM), a longer-acting form of methadone, has recently been withdrawn from use in Australia, Europe and the United States because of its potential to cause cardiac problems.

Opioid substitution treatment should be complemented by other services that address women-specific needs for medical care, prenatal care, substance abuse and psychosocial treatment, and attention to practical issues such as childcare, transportation, safe housing and outreach. Providing these other interventions can increase treatment retention. For example, a study by Bartholomew and colleagues [43] found that participation by women in a workshop that addressed assertiveness and sexuality issues was positively associated with the length of stay in methadone treatment.

Psychosocial treatment is particularly important for women whose life circumstances impact on their ability to stabilize their substance use, such as partner violence, sex work, poly-substance use, unsafe injection and sexual practices. Staff involved in substance abuse treatment programmes need to work closely with prescribing physicians and/or dispensing clinics to ensure that clients receive coordinated and consistent care.

The issue of physical and psychological safety should be addressed in opioid substitution clinics, particularly if a woman's partner or other significant male in her life is also receiving treatment at the same clinic. Because opioid substitution treatment protocols may require daily clinic attendance, programmes need to be particularly sensitive to such issues as the need for childcare, transportation and flexible hours of services, particularly for women who are juggling work and family/childcare responsibilities.

Methadone maintenance treatment

Methadone maintenance treatment is probably the most widely used substitution treatment for people who are dependent on opioids. Better results are achieved with longer retention in treatment, particularly when clients are provided with adequate dosages and access to counselling. Research has shown that when contrasted with treatments that do not use opioid substitution, methadone has been found to be more effective in retaining clients in treatment and reducing heroin use than non-pharmacological approaches [44]. Generally, studies have found similar benefits for women and men in methadone maintenance treatment.

Pregnant, opioid-dependent women should be given priority access to methadone maintenance treatment, which is recognized as the standard of care. Though detoxification might be an ideal solution for pregnant women, it has a very high likelihood of leading to relapse, endangering the health of mother and foetus. It is important to closely monitor methadone levels in

pregnant women to ensure adequate individualized dosage levels, in order to prevent women going into premature withdrawal and relapsing into illicit drug use. In the third trimester, the dose may need to be increased or divided into twice daily dosing in order to maintain methadone levels. Reducing a woman's methadone dosage does not reduce neonatal abstinence syndrome. Methadone can also be safely used by women who are breastfeeding. Methadone maintenance treatment for pregnant women has the following advantages, particularly if it is provided in the context of other needed services such as prenatal care [42, 45]:

- It is safe, medically supervised opioid use;
- There is better retention in treatment;
- Services such as antenatal care, treatment for HIV and other blood-borne diseases can be provided;
- There are better outcomes for the mother and the foetus;
- It provides an opportunity to involve substance-using partners in methadone maintenance treatment;
- There is a greater likelihood of the mother being able to care for her infant;
- It is inexpensive.

Buprenorphine

In some countries, such as France, buprenorphine is more widely used than methadone. It is preferred by some practitioners for use with younger clients, and it is showing promise for use with pregnant women. Recent studies have demonstrated a lower intensity of neonatal withdrawal symptoms with buprenorphine than with methadone. A Cochrane Library review [46] concluded that buprenorphine is an effective intervention for use in maintenance therapy for opioid dependence, but it is not more effective than methadone in adequate dosages. Some studies comparing buprenorphine and methadone have found higher retention rates and lower rates of illicit drug use among women maintained on buprenorphine. Buprenorphine has been approved for office-based use as an opioid substitution drug in a number of countries (e.g. Australia and the United States).

Amphetamine-type stimulant dependence

At this point there is insufficient evidence for the effectiveness of any medication for the treatment of cocaine or amphetamine dependence, though some research has been done on the use of anti-depressant medication for the treatment of the withdrawal from cocaine.

Issues for pregnant and parenting women

The literature indicates that women with substance use problems are more likely than men to be caring for dependent children, and lack of childcare is probably one of the most significant barriers to treatment access for women. Pregnancy represents not only unique risks to the health of the mother and the foetus, but also a unique opportunity to intervene, since pregnancy may be a time of high motivation and concern for the health of the foetus. Pregnant, substance-using women often have multiple life problems, including physical health problems such as HIV, hepatitis and other blood-borne diseases; sexually transmitted diseases; malnutrition and vitamin or mineral deficiencies; emotional or mental health problems such as low self-esteem, anxiety and depression or the experience of trauma. In addition, they may be living in an abusive relationship and have family histories of substance use problems. Some may be homeless and living on the streets, and some may be engaging in high-risk behaviours such as injecting drug use and unprotected sex.

Engaging and retaining pregnant and parenting women in treatment requires a high degree of collaboration between helping professionals, particularly those providing substance abuse treatment, prenatal care and child welfare services. These different sectors have different mandates and may also have a different understanding of, and attitudes towards, women with substance use problems who are pregnant or primary caregivers of dependent children. To overcome these barriers, substance abuse treatment agencies should consider developing agreements or protocols among themselves and with these other sectors, which would describe how they could work together to meet the needs of their mutual clients. The development of such agreements can also be an educational process that helps each sector understand the other's perspective and treatment approaches. It provides an opportunity to discuss legal and ethical issues, as well as other strategies, such as shared training to reduce barriers and enhance collaboration.

Providing appropriate interventions for pregnant, substance-using women can reduce substance use and improve birth outcomes. As has been found in outcome studies with other substance-using populations, the number of programme contact hours, rather than programme setting, is a major contributing factor to these positive treatment outcomes. However, some pregnant women may not be ready or able to stop their substance use, and others may be substance-free during pregnancy but not be ready to continue to abstain after the birth.

Contact in early pregnancy increases the possibility of developing a therapeutic alliance, as well as providing the opportunity to motivate women to change for themselves, not just in order to have a healthy baby. Prenatal care providers can promote early bonding by providing pregnant women with opportunities to see the developing foetus through use of ultrasound.

Studies have also found that women who are mothers and retain custody of their children and/or have their children with them in treatment remain in treatment longer than those who do not, and most studies have found a significant relationship between treatment retention and positive outcomes.

Described in box 20 are some key themes in providing appropriate services to pregnant and parenting women, based on the results of studies from the Pregnant and Postpartum Women with Their Infants programme of the United States Center for Substance Abuse Treatment.

Transmission of HIV and hepatitis from mother to child

Pregnant women often come to treatment with a range of health problems, including HIV and hepatitis. Guidelines developed by the University Hospital of Vienna for reducing transmission of HIV and hepatitis C virus (HCV) from mother to child are shown in box 21.

BOX 20

KEY THEMES EMERGING FROM EVALUATIONS OF PREGNANT AND POSTPARTUM WOMEN AND THEIR INFANTS PROGRAMMES

Key themes emerging from programmes funded by the United States Government under the Pregnant and Postpartum Women and Their Infants programme [47, 48] are:

- Respectful service philosophy, which addresses women's shame and guilt, loss of control over their lives and their mistrust of the systems scrutinizing them, by providing an environment that is non-judgemental and promotes mutual respect and empowerment and builds on women's strengths.
- Comprehensive and practical care by combining substance use treatment with an array of services such as prenatal care, medical care, parenting education, family planning, attention to nutrition and housing needs and counselling on violence and relationship issues, as well as practical supports such as babysitting costs and transportation to appointments. A philosophy that supports women's choice in the life areas they want to work on and provides "one-stop shopping" or a well-integrated network of services contributes to programme effectiveness.
- Inter-agency collaboration and coordination to engage and retain women in treatment and provide the range of services required. Inter-agency collaboration and coordination can address issues such as differing service philosophies and approaches, promoting joint training, sharing of resources and joint planning and, in particular, promoting collaboration between the addiction treatment system, the child welfare system and the foster care system.
- Broad and flexible continuum of care, which can support women in entering, re-entering and completing treatment.
- Outreach to reduce internal barriers, such as shame and fear, and to make pregnant women aware of available services either directly through interventions, such as street outreach, or through education of other service providers. Home outreach and transportation are important factors in treatment compliance and outcome.
- Case management and flexible scheduling, which may include home visits, telephone contact, professional or peer advocacy, help with transportation and processes that allow women to enter and re-enter treatment and accommodates their need to attend to other issues such as medical appointments or responding to child welfare authorities.
- Attention to family issues, by integrating children and partners into women's care and supporting women in their decisions regarding reunification or disconnection, is a critical component of effective care for pregnant and parenting women.
- Continued support or aftercare is critical for women because of the many changes that they experience following the intensive phase of treatment. This includes developing new social networks, relationship issues, family-role changes, working on relapse prevention strategies, etc.

BOX 21**REDUCING THE TRANSMISSION OF HIV AND HEPATITIS C VIRUS FROM MOTHER TO CHILD**

The University Hospital of Vienna provides outpatient services to pregnant, substance-using women through the pregnancy and drug addiction clinic of the Department of General Psychiatry. It has developed guidelines for pregnant women with HIV and hepatitis C as follows [42]:

1. HIV:

- Scheduled Caesarean delivery: 38th week
- Antiretroviral treatment (consider drug/drug interaction)
 - During pregnancy (after week 14: delivery)
 - For neonate HIV Negative: 4 weeks of treatment
HIV-Positive: continued treatment
- No breastfeeding

2. Hepatitis C:

- Normal delivery
- Breastfeeding possible, depending on the viral load
- No initiation of treatment for hepatitis C virus during pregnancy or breastfeeding

Case studies

The case studies described below illustrate various models for programmes that address the needs of pregnant and parenting women. Most of the programmes are gender-specific, with the exception of the one in Kenya. They also represent a range of levels and types of treatment services—outpatient (drug-free and substitution maintenance), residential and therapeutic communities.

Australia: Detoxification and residential treatment for women with children

Name: Jarrah House
 Country: Australia
 Contact person: Barbara Rich
 Contact information: P.O. Box 6026 Adelaide, Malabar, New South Wales 2046
 Telephone: +(61) 296616555
 Fax: +(61) 2996 16595
 E-mail: info@jarrahouse.com.au
 Web site: www.jarrahouse.com.au
 Status: non-governmental organization; ongoing funding; years of operation: 20 years

Background

No services existed for women in Australia and women could not access treatment if they had to leave their children at home (because of no existing childcare facilities). Also, many women with histories of domestic violence or sexual assault were unwilling to be in a mixed-gender unit.

Objectives

The objectives are to provide medical detoxification and short-term rehabilitation for women and their children.

Activities

Project start-up: The first women and drugs conference in Adelaide identified the need for this type of service. The management committee approached a government minister directly and received a grant. Following a positive evaluation, ongoing funding has been provided by the State and Commonwealth Health Departments. A major challenge has been finding an appropriate building. This year Jarrah House received a grant for a purpose-built building.

Treatment programme: Jarrah House is a residential treatment facility with 12 detoxification beds and 12 rehabilitation beds. There is a 21-day detoxification phase, and a six-week rehabilitation phase. The programme components include: case management, family therapy, individual counselling, a parenting programme, cognitive-behavioural treatment-based therapy and outpatient psychodynamic groups. It concentrates on common issues such as domestic violence, sexual assault and parenting. The programme takes a social view of health, and the case management component addresses issues such as poverty, homelessness and childcare support to augment the programme content. Clients are involved in evaluating all aspects of the programme and participate in any planning sessions to ensure that it continues to be responsive to the needs of the client groups.

For women with children, Jarrah House has a capacity to serve eight children up to eight years of age whose mothers are in either detoxification or rehabilitation. Some of the children are neonates who are referred with their mothers directly from neonatal intensive care. For pregnant women, Jarrah House provides co-case management, special access arrangements for specialized prenatal care, parenting groups and individual case management by early childhood teachers and family therapists.

Clients served: The clients served are women from 16 to 65 years of age; all substances. The programme is state-wide, but because it has the only detoxification service in Australia that accepts women with children, it also takes referrals from other states.

Staffing: All staff are female and trained in women's health and other issues pertaining to women.

Results/accomplishments

Accomplishments include: reduction in the number of children removed from their mothers' custody; higher retention rate in treatment than the national average; three times higher representation of the indigenous population in treatment than the national average; and earlier intervention for pregnant women. Also, individual case management and the group therapy programme were evaluated most highly by clients as being the most useful.

Jarrah House employs a number of mechanisms to measure the impact of its programme, including: national data collection that includes information on demographics and treatment episodes; follow-up interviews one month after discharge focusing on compliance with and success of discharge planning; client satisfaction surveys; client focus groups; and client surveys. The programme has also been evaluated by independent researchers [8] using a quasi-experimental design.

Challenges

At the system level, the biggest challenge in serving women who are pregnant or have children is maintaining therapeutic neutrality in the face of mandatory child protection notification and pressure by the Department of Community Services. Written resources that explain in detail the various relevant child protection issues, individual case management, case conferencing with child protection agencies and effective partnerships with child protection agencies have been successful in addressing these problems.

Other system challenges include the lack of available medical specialists and continuity of care for women from a huge geographical area.

The service also faces enormous demand, and waiting times are a problem, as is the limited number of spaces available for children. Jarrah House has a waiting list, and staff maintain daily contact with prospective clients in order to provide support. There is also a system for prioritizing high-risk clients. Jarrah House has also developed memorandums of understanding with referring agencies.

At the client level, a major challenge is the prevention of relapse for women with few resources, since the programme does not control the availability of housing, childcare etc. The programme attempts to overcome these issues through better discharge planning and continuity of care to increase the likelihood of clients accessing resources in their own communities. Jarrah House has also provided a community alumni group and tried to build links with welfare and housing.

Lessons learned

Women require specialized treatment to address their unique needs.

Brazil: A women-only outpatient programme

Name: Programa de Atenção à Mulher Dependente Química (Drug-Dependent Women Treatment Center) (PROMUD), Institute of Psychiatry, Clinic Hospital, São Paulo University Medical School
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Status: governmental organization with ongoing funding; years of operation: 7

Background

The programme was created in 1996 based on the experience of working with people with substance use problems. A study of the specific characteristics of Brazilian women with substance use problems and a review of the national and international literature indicated that women had specific needs and benefited more from women-only treatment services. At that time, there was no similar programme for women in Brazil.

Objective

The objective is to provide free, gender-specific treatment for women.

Activities

Treatment programme: The Programa de Atenção à Mulher Dependente Química (PROMUD) of Brazil is an outpatient, gender-specific programme. Gender-specific inpatient treatment is provided for women with severe medical or psychiatric problems, or women who do not respond to outpatient treatment. Women can be self-referred, referred by the Psychiatric Institute with which PROMUD is affiliated, or referred from other units within the hospital, which serves a mainly low-income population. Following referral, women are individually assessed. The programme has space for up to four admissions per week. Women must have a Diagnostic and Statistical Manual of Mental Disorders (DSM-IV) diagnosis of psychoactive substance dependence to be admitted.

PROMUD combines cognitive behavioural approaches for some aspects of treatment, such as relapse prevention, with psychodynamic approaches to help women understand their deeper emotions and pain and find non-drug alternatives to dealing with feelings such as rage or depression. Treatment components include medical-psychiatric care and referral to specialist services if required, a weekly psychotherapy group for up to 3-4 years, an art therapy group, nutritional counselling, body-expression activities, legal counselling, a group for pregnant women and their partners, and an early intervention plan for women with children (due to lack of financial resources, the latter two activities are temporarily on hold). Most of these activities are weekly or bi-weekly.

The inpatient treatment programme offers psychiatric care, individual psychotherapy, family psychotherapy, individual occupational therapy, and nutritional counselling for women with co-occurring eating disorders. PROMUD also has a research division and a teaching programme, including a graduate-level course.

Staff: The treatment programme is staffed by a multidisciplinary, professional team. An initial step in the creation of the programme was to recruit a multidisciplinary team of psychiatrists, clinical doctors, a psychologist, occupational therapists, nutritionists and social workers and provide them with training in addiction-related cases.

Clients: PROMUD serves women with a psychoactive substance dependency (according to DSM-IV) who are 18 years and older and live in greater São Paulo.

Project results/accomplishments

Alcohol and drug-dependent women in the PROMUD programme stay longer in comparison with women attending the mixed-gender programme at 3, 6 and 12 months.

Seventy per cent of female graduates of the PROMUD programme have demonstrated partial or complete improvement in global functioning and a reduction or abstinence from alcohol and other drugs.

Challenges

The lack of financial resources is a major challenge, with many of the team members working on a volunteer basis; there is a lack of physical space for conducting all the groups that are needed.

Clients continue to experience barriers to accessing the programme. These include fear of discrimination, which the programme tries to overcome by offering a women-only programme and specially trained staff; fear of losing custody of their children (the programme provides a specialized lawyer to give women legal counselling) and lack of money to pay for transportation to PROMUD, which is located in the centre of the large city of São Paulo.

Lessons learned

It has been noted that a women-only programme brings drug-dependent women into treatment, but women's programmes may face the same prejudices and discrimination as women clients do in their daily lives. Furthermore, there is a need for programmes such as PROMUD, in which a trained and motivated multidisciplinary team addresses women's special needs (nutrition, legal support etc.) and emphasize outpatient treatment with psychotherapy.

The PROMUD programme has demonstrated the success of attending to the specific needs of substance-dependent women by having components that address substance dependency, family, social and individual problems; offering women-only psychotherapy groups; having women as the majority of the professional staff; and employing staff that are highly motivated.

Kenya: Serving women in a mixed-gender residential programme

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 Status: non-governmental organization with time-limited funding; years of operation: 9

Background

The Omari Project was initiated because heroin use was causing a great deal of suffering among young people and their families in tourist centres such as Malindi and Watamu. There were no services, and there were few ideas about how users might be treated. The project aims to address the particular needs of heroin users.

Objectives

The objectives are to support Kenyan heroin users in becoming substance-free, and prevent infection and transmission of HIV and other blood-borne and sexually transmitted infections.

Activities

Start up: Funding was obtained to purchase land on which to build the residential treatment centre, which can accommodate 20 residents (both men and women). This funding followed previous youth prevention initiatives with financing from the United Nations Office on Drugs and Crime and the British Council.

Treatment programme: The programme is a six-month residential rehabilitation programme, which is free of charge. It includes initial withdrawal from heroin, group and individual counselling, family seminars and visits, exercise and preparation for work placements.

Senior residents, who have completed at least three months of the programme, take much of the responsibility for the day-to-day management of the centre. There has been a strong demand for places in the centre, and there is always a waiting list. There is also an outreach programme that provides follow-up for the graduates of the residential programme and contact with new users for referral and harm reduction services. The Omari Project has recently opened two drop-in centres where information, counselling and referral on substance use and sexual health issues are offered.

Staff: The residential centre has 10 staff members. There has been difficulty finding female staff members who are able and committed to the work. For the past two years a British woman volunteer has been able to provide individual counselling to women who speak good English. Priority is being given to recruiting additional female staff, and a woman was employed as a support worker in 2003. The support staff has received training in working with women heroin users and their physical, emotional and social needs.

Clients: Ninety per cent of the clients are male, reflecting the male/female ratio of heroin users in the community. Clients are generally in their twenties and thirties, and the majority are Muslim and use heroin, as well as other substances such as cannabis, khat, Valium®, other prescription drugs and alcohol.

Accomplishments/results

The local community and authorities have been kept informed through a series of workshops, which have been held for health workers, police, local government, religious groups and women's groups in order to maintain their support for the programme.

The project has taken the best international practices and adapted and applied them to the cultural setting of coastal Kenya. It is a well-established programme that serves people from families who cannot pay for treatment.

Women heroin users know that the services are open to them, and that they will not be stigmatized or discriminated against. A flexible approach to the needs of individual women has been adopted; for example, a pregnant woman and a woman with a newborn baby have been admitted.

Linkages have been made with a local non-governmental organization that provides training opportunities to "women in distress", mainly women involved in the sex trade.

Since the residential programme opened, there has been a significant shift in attitude by staff, who are now committed to making the needs of women heroin users a priority.

Challenges

There are several obstacles to overcome in order to improve the project. For example, potential funding sources need to recognize that there is a serious heroin problem in coastal Kenya, particularly for ongoing service

provision as opposed to prevention, since heroin users are an unpopular cause; training staff, particularly women, to work with heroin users in Kenya; breaking down the resistance from the local community to a service that welcomes women as well as men.

Generally, women heroin users are more discriminated against than their male peers. Some community members think of women as being disruptive and deviant and believe the women's treatment to be secondary to that of the men. Because of this, although women users know the service is open to them, they are deterred from seeking treatment and do not go to the residential centre.

Lessons learned

The main lesson learned here is that the lack of employment opportunities hinders the success of graduates. Further observations include noting the slow rate of behaviour change and the necessity of follow-up support after completion of the programme.

Sweden: A women-only therapeutic community programme

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 Status: governmental organization, ongoing funding;
 years of operation: 14

Background

Between the years 1980 and 1990, several scientific studies of the different treatment programmes in Sweden were being carried out. These studies showed poor results for women with substance use problems when they were treated in mixed-gender programmes, with less than 20 per cent of women completing treatment. As a result of these studies, the Government granted the City of Malmö funds to analyse the need for a gender-specific treatment programme for women. This led to the opening of Sofia in 1990.

Objectives

The Southern Social Services authority in Malmö specified the following objectives for Sofia in 1990:

- To help women deal with substance use and other underlying problems to enable them to lead a life free of drug abuse;
- To intervene at an early stage, as this is positive for both the pregnant woman and her baby;
- To improve the women's ability to form positive relationships with their children, partners, relatives, friends and other people close to them by adopting a holistic approach;
- To help women make the most of their abilities in order for them to be able to live socially independent lives;
- To stretch the limits of, and further develop knowledge concerning, psychosocial treatment for women.

Activities

Start-up phase: A director and assistant director were hired respectively in 1989 and 1990 to start planning for Sofia and to recruit staff. A reference group was formed with representatives of the social service administration to provide input into the treatment programme. The director also talked to politicians and heads of municipal social service offices to get their input into the programme. This proved useful later on. At the time Sofia was planned and implemented, treatment for women was a "hot" issue and there was a lot of commitment from decision makers and social workers in the field. Since then, however, there has been less commitment to women's treatment, and the funding for Sofia has been questioned. Thus, the initial links with politicians and others in senior positions have been important in maintaining Sofia.

Treatment programme: Sofia is a gender-specific, long-term, drug-free residential programme, with a therapeutic environment adapted from the model developed by Maxwell Jones. Treatment lasts for up to one year, followed by a year of aftercare. In the aftercare phase, Sofia may collaborate with a drug substitution programme, but the treatment programme's intention is to help women lead a life free from substances.

The working method is based on a psychodynamic perspective of human psychological development. The programme responds to the needs of women by providing treatment that is focused on the relational aspect of women's lives. It is built on the assumption that the identity of women is connected to "the relating self", with a focus on:

- Children and relationships with children;

- Pregnancy and increasing consciousness of how to take care of and be able to welcome the newborn child;
- Increasing consciousness of exploitation from partners and suppression in a patriarchal society; and
- Gender roles, as an important issue in general, and in the context of substance abuse in particular.

The programme is tolerant of relapses, and these are not seen as a reason to discharge clients. Relapsing clients must leave but are welcomed back when they have stopped using substances and are ready to try again.

The programme employs individual therapy, small group sessions and daily community meetings. The relationship with a primary counsellor is considered to be the key to enabling women to develop trusting relationships. It is considered the best method for working with women who have experienced violence and abuse. Part of the treatment experience is providing women with an opportunity to reflect on their relationships and make necessary changes. Spouses or partners are allowed to visit the women during their treatment stay, and at weekends they can stay at Sofia for one or two nights. People in a woman's relational network also meet with a woman's primary counsellor in group sessions, in order to make the relational network function in a constructive way to support a woman in a substance-free lifestyle.

Services for pregnant women: Sofia cooperates with Enebackens barnhem, a children's care home in Malmö. During their pregnancy, women participate in the Sofia programme, where they focus on becoming a mother. They then move to Enebackens barnhem after the birth where the treatment focuses on the mother-child relationship. At the same time, women continue to receive counselling from Sofia. Expecting a child is seen as an opportunity for change and pregnant women are encouraged to seize the opportunity to gain new perspectives in self-value as a mother.

Clients: The typical Sofia client is in her middle or late twenties, with a long history of substance use problems. She has often experienced assault, violence and sexual abuse and has been involved in the sex trade.

Staffing: Sofia has a staff of 11 women.

Results/accomplishments

Based on an evaluation done in the period 2001-2002, which followed up 123 clients who had received treat-

ment in the previous 10 years, and on in-depth interviews with 20 women, approximately 50 per cent of women were substance-free and had made other changes in their lives.

Furthermore, the following were identified as important elements of the programme: gender-specific treatment, individual counselling, the opportunity to connect and make friends with other women, continued support after a relapse, relationship and social support.

Challenges

At the system level, the biggest challenge has been to ensure continued funding for Sofia and other services, such as detoxification. In times of reduced funding, women's substance abuse services are not seen as a priority. A further challenge has been to make social services refer pregnant women to the programme.

At the programme level, the group process is difficult for some women who have been part of the drug subculture for many years. Also, organizational change can be disruptive to staff and clients and may result in greater client drop-out during these periods.

At the client level, women continue to experience many barriers when seeking treatment, such as: being suspicious of other women, which makes them reluctant to seek gender-specific treatment; experiencing shame and not wishing to be identified as a female addict; being afraid of seeking assistance from the social services administration and losing custody of their children; resistance from partners who do not want their women to go to treatment, particularly if they also have a substance use problem; and lack of self-esteem and confidence.

Lessons learned

For programme sustainability, it is important to create alliances and linkages with the organizations in charge of drug services, to maintain good relations with the surrounding community, to document the programme and to promote good publicity.

Important elements of gender-responsive services are: being treated by other women, acceptance of relapses, individual counselling sessions, friendship with other women, aftercare and long-term planning of treatment, dealing with women's relatives, social support and creative activities.

United States: A women-only methadone maintenance programme

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Status: The Women in Treatment programme is subsidized by the Department of Mental Health and Addiction Services, which is ongoing. The project has been in operation for 12 years.

Background

The programme was initiated to focus on issues critical to women in treatment: parenting, health and domestic and sexual abuse. Women in Treatment (WIT) and Holistic Women's Services (HWS) are both part of the Orchard Hill Treatment Services, one of three methadone maintenance clinics run by the APT Foundation. HWS is only for women who are HIV-positive or living with AIDS.

Objectives

The objectives are to offer methadone maintenance and treatment to women in a model that is culturally focused; to enhance women's ability to focus on treatment by providing on-site childcare; to provide specialized treatment to women who are HIV-positive or living with AIDS.

Activities

Start-up: Information was gathered from community and state agencies concerning the target population. A committee was formed to investigate need in the area. It was determined that inner city women were underserved, and a request had been made for a gender-specific programme. At the time, there was a six-month waiting list to get into methadone treatment, and the only gender-specific programme was a pregnant women's group. Funding was sought from the Center for Substance Abuse Treatment for 75 treatment slots to make methadone treatment more accessible to women.

Treatment programme: WIT is designed to meet the needs of women with substance use problems by providing the following: methadone maintenance treatment, psychiatric evaluation and concurrent treatment

(except for women with severe psychiatric problems, who are referred to local community mental health agencies), group and individual counselling, family counselling as needed, on-site childcare during treatment hours, case management services, primary health care and vocational services (which are provided through another part of the APT Foundation services). WIT also has links to community agencies to which it refers daily. WIT believes that truly effective treatment must concern itself with substance abuse, psychological history and socio-economic factors. Women who are pregnant are given special care. Nursing staff are alerted about pregnancies and meet with the women to address any concerns that they may have. If they wish, pregnant women may be transferred to the pregnant women's programme, which is offered through another component of APT Foundation services.

Clients: The clients are women who are 21 years of age or older, who have been addicted to opiates for one year or longer and who are from the New Haven, Connecticut, catchment area.

Results/accomplishments

Based on 2003 satisfaction surveys, over 80 per cent of programme participants reported a reduction in symptoms. Women felt staff were sensitive to cultural issues and that services were offered at convenient times.

Impact and success are measured in different ways, including women completing annual satisfaction surveys; encouraging women to participate in focus groups exploring strengths or barriers to services; monthly quality assurance measures, which examine discharge data; the percentage of positive toxicology tests; and the number of clinical contacts.

Challenges

Cutbacks to health insurance reimbursement, due to nationwide health-care cutbacks, have made it more difficult for women to access treatment. Transportation to the programme was an issue for clients; though this was overcome by applying for state assistance services for bus passes and taxi rides, funding cutbacks have reduced transportation benefits.

Lack of childcare facilities was a barrier that was overcome by providing on-site childcare; however, cutbacks have reduced the hours of operation of the childcare component, making it more difficult for women to access treatment. Getting pregnant women to voluntarily access prenatal care and to maintain an adequate

dosage of methadone was a barrier that has been overcome by meeting with the nursing staff and maintaining a file on the progress of each woman's pregnancy.

Lessons learned

Women are able to enter and remain in treatment when their needs are listened to and addressed; utilization of a harm reduction philosophy and examining current trends/needs for people dependent on opioids have been crucial to retaining women in treatment. The most successful components of the programme are on-site child-care, individually adjusted methadone dosage to accommodate each woman's need, access to psychological services and linkages with community hospitals and agencies that care for patients who are HIV-positive. Also, working closely with other community agencies to facilitate/coordinate services is a key to success.

United States: Comprehensive services for women

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 Status: non-governmental; Marin Services for Women receives both ongoing and time-limited funding from a variety of sources, including government grants and contracts, insurance contracts, corporate and foundation grants, individual donors and client fees; years of operation: 25

Background

A group of women who were recovering alcoholics had the idea that women needed a safe supportive place to live while establishing recovery through Alcoholics Anonymous. At the time there were no services specifically for women in Marin County, but there was an agency in Redwood City called Women's Recovery Association (WRA), which had been established a few years earlier. The founders of Marin Services for Women (MSW) reached out to the staff and board of directors of WRA for help in establishing a similar programme. MSW was incorporated as a non-profit organization and applied for and received funding from the National Council on Alcoholism to begin providing services. The founding of MSW was a pioneering, grass-roots effort. In 1978, federal funding "set-asides" for women's services

had only recently been established. There was virtually no research that focused on women's experience of chemical dependency or their unique needs in recovery. Women received services in mixed-gender settings where the treatment approaches were based on experience with chemically dependent men.

Objectives

The objectives are to advance community health by providing chemical dependency recovery services to individual women; to link addiction recovery with personal, relational, social and economic empowerment; and to undertake community education regarding the nature, prevention and treatment of chemical dependency.

Activities

Start-up: The MSW founders' assessment of the extent of the problem of addiction (which at the time was addiction to alcohol) was based on their experiences in Alcoholics Anonymous, the extremely limited writing available on women and addiction and anecdotal evidence from WRA. The founders worked with city officials and the county office on alcoholism, which at the time was separate from the office on drug addiction. Much of the early staffing was on a volunteer basis, and the programme model was almost exclusively based on the 12 steps of Alcoholics Anonymous. In the 1980s, MSW began accepting clients with drug problems in addition to those with alcohol problems and added outpatient and perinatal services. MSW has evolved from a "recovery home" based only on the 12 steps of Alcoholics Anonymous into a progressive, innovative agency committed to research-based practice that still incorporates the 12-step models.

Treatment programme: During the past five years, MSW has updated and expanded its programmes into a full continuum of care that provides residential treatment, intensive outpatient day treatment, evening outpatient treatment, continuing care, an anger management group, a trauma recovery group and transitional housing. This allows MSW to help women to make the transition from one modality to another and to provide the most appropriate level of care, resulting in more effective service utilization, from both a clinical and a fiscal perspective.

MSW programmes utilize an empowerment-based approach to working with clients and their families. Core components of this approach include: non-judgemental respect for the client at all times; use of non-punitive consequences when clients choose not to comply with programme guidelines; reframing and validation of

clients' strengths at every opportunity; and a partnership process between client and staff at every stage of treatment: assessment, treatment planning, implementation, discharge planning and continuing care.

MSW is committed to maintaining a welcoming, safe and uplifting environment in the facility, which supports self-esteem, dignity and productivity for staff and clients alike. The programmes serve pregnant and parenting women and accept preschool children who live in residential treatment during the mother's stay. Staff are knowledgeable about women's identity development, self-esteem and shame issues and women's mental health needs, and the programmes address all areas of a woman's life as needed: housing, transportation, childcare, vocational training, mental and physical health care, reproductive health, anger management, relational violence, parenting, financial, legal and relationship issues.

MSW programmes are trauma-specific, using trained counsellors to facilitate research-based trauma recovery curricula developed by leading researchers such as Dr. Stephanie Covington at the Institute of Relational Development and Center for Gender and Justice and Dr. Lisa Najavits at Harvard University. Client's issues relative to physical and psychological trauma are understood to be key to the addictive and recovery processes for women.

MSW operates a fully staffed, on-site child development centre for children of both residential and outpatient clients. Children's health care and well-checks are facilitated. Children are assessed for trauma issues, developmental difficulties and alcohol and drug effects and are referred to community resources as appropriate. Pregnant and parenting clients receive parenting and child development education as part of their programme and participate cooperatively in the child development centre for four hours a week. Pregnant and parenting clients generally have a longer length of stay than non-parenting clients.

Clients: Clients are women 18 years of age and over (the majority of them are in their early twenties or mid-thirties) who are dependent on alcohol and other drugs (marijuana and methamphetamine are predominant). MSW serves the greater San Francisco Bay Area (nine counties). Over 90 per cent of clients are women with low or very low income.

Results/accomplishments

Since its beginning, MSW has provided services to over 3,000 women and their families. It also has the highest

programme completion rate of all programmes in Marin County, based on information provided by the Marin County Office of Alcohol and Drug Programs. Programme graduates maintain involvement with MSW through their weekly continuing care groups, the alumni association, service on the board of directors or as paid staff.

Seventy-six per cent of programme graduates continue to maintain recovery after 12 months. The recently acquired facility will increase the annual number of women served, from approximately 250 to approximately 525. Finally, because of the relational orientation of women, recovering women have a significant impact on not only their families, but also the entire community, and thus all programmes remain consistently full and have waiting lists.

MSW measures success through statistical analysis of data relative to admissions, completions, 12-month follow-up, improvement in legal, family reconciliation and employment issues. MSW is not satisfied with the significance of these measures, and the agency is committed to future development of a woman-specific evaluation model, for which funding is already being sought.

Challenges

MSW faces several challenges, for example, insufficient capacity to meet service demand, which is being addressed by moving to a new facility that will double the residential capacity; obtaining funding to provide high-quality services for low-income pregnant and parenting women and their children, which is being addressed by diversifying the funding mix; and retention of a high-quality multidisciplinary staff who can consistently implement the MSW empowerment approach.

Lessons learned

To establish and maintain stable recovery, women need to feel safe enough to allow themselves to hope for a life free from addiction. The experience at MSW validates research indicating the superior efficacy of women-only programmes, staffed by women. MSW has also learned that it can successfully find the resources it needs. Furthermore, by empowering the clients, staff and board of directors to have a voice and participate to their fullest potential, a synergy of compassion, respect and hard work will be generated in the interests of improved individual and community health.

Austria: A hospital-based, medication-supported outpatient programme for pregnant women

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 Status: government organization with ongoing funding; years of operation: 10

Background

The 1980s witnessed an overall increase in substance abuse, with rising numbers of pregnant, opioid-dependent women presenting themselves to medical facilities. Some came early in their pregnancies and received ongoing prenatal care, but others only sought help at the time of delivery because they feared the involvement of child welfare authorities. At the time, there was no specific facility providing multi-professional and interdisciplinary treatment for this patient population, as the generally accepted therapy standard for pregnant addicted women was detoxification. However, in many cases, abstinence was often unachievable for these patients. As a result, they relapsed into a cycle of substance abuse and withdrawal that often culminated in an adverse outcome for mother and child.

Objectives

The objectives are to reach substance-dependent pregnant women through outreach activities, in order to integrate them into a programme of comprehensive care as early as possible; to maintain opioid-dependent pregnant women on synthetic opioids (e.g. methadone, oral slow-release morphine or buprenorphine); to provide interdisciplinary and multi-professional therapy for this patient population, including treatment of psychiatric and somatic comorbidity, psychotherapeutic and psychosocial care; to optimize the health status and well-being of the newborns by providing sufficient pre- and postnatal care; and to include fathers in treatment to enable both parents to reach a satisfactory level of stabilization and to help them to reach the goal of raising their children (60 per cent of the pregnant addicts have substance-dependent partners).

Activities

Treatment programme: This comprehensive care programme at the Addiction Clinic, Department for Psychiatry, Medical University of Vienna, has been established to address the specific needs of opioid-dependent pregnant women and their children.

In terms of internationally accepted treatment standards for this patient population, the Addiction Clinic provides opioid maintenance treatment using methadone, oral slow-release morphine, and buprenorphine, as well as psychosocial and psychotherapeutic support. The programme works with other departments of the Medical University of Vienna, including the Department of Gynaecology, which sees women for six prenatal visits and delivery; the Department of Neonatology, which provides appropriate treatment to newborns who develop neonatal abstinence syndrome; the Department of Physical Medicine, which offers body-oriented therapy; and Child and Adolescent Neuropsychiatry, which completes the comprehensive care network and does follow-up visits of parents and children, including four examinations during the first year.

Patients: The mean age of pregnant, substance-dependent women at their first visit at the Addiction Clinic ranges between 20 and 30 years (one third of opioid addicts are females of childbearing age). Poly-substance abuse is common; the drugs involved include opioids, cocaine, benzodiazepines, nicotine, alcohol, amphetamines and cannabis. Opioid-dependent women show a high incidence of psychiatric and somatic comorbidity, including anxiety and depression (up to 50 per cent of this patient population suffers from depressive disorders), sexually transmitted diseases, infectious diseases such as hepatitis C and HIV/AIDS, liver disease, anaemia, malnutrition and vitamin/mineral deficiencies. In addition, many of the women have low self-esteem, live in abusive relationships, have a family history of parental chemical abuse and have low motivation for treatment.

Results/accomplishments

The programme has achieved a retention rate of 98 per cent. Eighty-five per cent of neonates are rated at birth as being children of healthy mothers, with the exception of being small for their gestational age, which might be related to their mother's smoking. Eighty per cent of newborns are able to stay with their mothers.

Research has been carried out based on the work of the clinic [49-52].

Challenges

Establishing contact with pregnant addicts is difficult, as women with substance use problems access prenatal care late in their pregnancies. Other challenges include matching the appropriate substitute substance and maintenance dosage to patients' needs. This helps to achieve satisfactory levels of stabilization, to avoid concomitant use of illicit substances by pregnant women and to minimize neonatal withdrawal symptoms.

Lessons learned

Opioid maintenance therapy, in combination with a multidisciplinary team approach, can engage women at an earlier stage of pregnancy and improve outcome for the mother and the newborn. Women and their partners are retained in treatment when opioid maintenance therapy, diversification of psychopharmacological treatment and psychosocial and psychological support are provided and when the multidisciplinary team works from one location. Diversifying maintenance medication and treating concurrent disorders reduce concomitant consumption of illicit and non-illicit substances. Aftercare for the mother and child is essential to the success of the programme and to improving patient outcome.

Canada: An integrated outpatient programme for pregnant and parenting women and their children

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 www.mothercraft.ca
 Status: non-governmental organization receiving funding from Health Canada granted on a three-year granting schedule and reviewed for renewal every three years; years of operation: 9

Background

The initial impetus for Breaking the Cycle (BTC) grew out of a 1992 conference organized by the Infant Mental Health Promotion Project of Toronto and the Metro Toronto Addiction Treatment Services Committee. Recommendations from the conference noted the urgent need to develop an integrated early identification

and prevention programme for pregnant women and substance-involved families with young children. The goals were to address existing service system problems such as fragmented services for substance-involved mothers and their children; multiple intake experiences; poor coordination of services, especially between the adult treatment sectors and the children's service sector; lack of consistency; and multiple locations for service access.

Objectives

The objectives are to reduce risk and enhance the development of substance-exposed children by addressing maternal addiction problems and the mother-child relationship in a comprehensive, integrated and cross-sectoral model.

Activities

Start-up: During the period 1993-1994, four agencies collaborated in designing a cross-sectoral initiative, drawing upon their respective expertise (women's addiction services, child and family development, child welfare and health care). A literature and research review was completed to confirm the need for a comprehensive response to women's substance use problems. In May 1994, with funding from Health Canada, a consultant was contracted to examine the unique Metro Toronto market needs; to undertake community consultations with professionals, as well as with clients; and to review literature on model programmes elsewhere. This development phase resulted in the refinement of the model design based on the following principles and features:

- *A collaborative, community-based response*, which recognizes that there is not one single agency that is able to appropriately address the multiple and complex needs of parents and children who are substance-involved;
- *A comprehensive, integrated, cross-sectoral system response* that reorganizes and delivers existing services in an improved manner, recognizing that services should be coordinated so that agencies adapt to families, rather than families having to adapt to multiple agencies;
- *Prevention through early identification*, which embraces the belief that, with time and acceptance, even the most high-risk woman can be engaged in a process of planning for her children;
- *Improved parenting skills and the prevention of child abuse* by providing women with information about the risks of substance use, promoting the reduction

of maternal substance use in pregnancy, encouraging optimum planning for the birth, supporting the mother's efforts to provide optimum parent-infant bonding and creating opportunities for developing maternal self-sufficiency;

- “*Single access*” model, which not only increases the *availability* of multiple services, but also coordinates the delivery of these services out of one location; and
- *Evaluation*, in order to test and further develop the model.

In April 1995, BTC was launched by four lead partners: the Canadian Mothercraft Society, the Jean Tweed Treatment Center (a women-only substance abuse treatment centre), the Children's Aid Society of Metropolitan Toronto (child welfare) and the Motherisk programme at the Hospital for Sick Children. Subsequent to the opening of the Center, a fifth partner was added, the Toronto Public Health Department. In 1996, the Catholic Children's Aid Society of Toronto became the sixth partner, and in 2003 the St. Joseph's Health Center joined the partnership.

Treatment programme: BTC provides a range of services to serve pregnant and/or parenting women with substance use problems and their children aged 0-6 years, through a single access model, which offers individual and group addiction treatment, parenting programmes, childcare, child developmental services (including screening, assessment and intervention), health/medical services (including pediatric clinic, addiction medicine clinic), mental health counselling and basic needs support (including food, clothing and transportation).

The BTC pregnancy outreach programme offers street outreach services to engage homeless, pregnant women using substances in health, treatment and social support services. This service was put in place following a study that indicated a lower engagement rate for pregnant women (22 per cent) than for parenting women (78 per cent). It was also recognized that homeless, pregnant substance-using women had greater barriers to accessing health and treatment services than pregnant substance-using women who were not homeless. BTC also works closely with providers and services that dispense methadone maintenance treatment to women who also access BTC services.

BTC uses motivational interviewing strategies within the stages of change to support women to build commitment and to set personal goals for change. Use of a harm reduction approach recognizes abstinence as an ideal outcome but accepts alternatives that reduce harm.

This approach allows for acknowledgement of individual goals for change and facilitates a respectful, non-judgemental approach that allows women to set goals for improving their health that may not give immediate priority to substance use issues. All addiction-related services are women-only. Partners may participate in parenting programmes at the discretion of the woman.

Clients: The mean age of clients at BTC is 30 years, the primary drugs of choice being crack cocaine and alcohol, and the average history of substance use is 10 years. Clients have an average of two children (range: 1-12 children) and one third of the children are in their mother's care, one third are in the care of a family member and one third are in the care of the Children's Aid Society.

Eighty-two per cent of women report a history of physical abuse, 84 per cent emotional abuse and 70 per cent sexual abuse. At intake, over 70 per cent of women report having experienced the following symptoms in the previous six months: depression, anxiety disorder, eating disorder (approximately one third report concurrent eating disorders), violent thoughts or feelings, fears/phobias and amnesia. Suicide attempts, legal problems and poverty are also issues for BTC clients.

Results/accomplishments

Based on a number of evaluations, the programme has been successful in achieving its objective of reaching and engaging a very high-risk population of women. As a result, women have improved access to services such as prenatal services and child welfare services, improved newborn outcomes and mother-infant interactions, and improved sobriety. An evaluation of the pregnancy outreach programme found that it had been successful in reaching its target population of pregnant homeless women early in their pregnancies, resulting in improved birth outcome among those women reached in the first two trimesters of their pregnancies.

Challenges

Acquiring funding to operate a unique programme that targets a hard-to-reach population, implementing an innovative model and involving partnerships among sectors that had previously not engaged in service partnerships (i.e. adult treatment and children's services). In addition, significant challenges of developing and implementing a multisectoral model were observed. These were addressed by achieving agreement on a number of key issues such as vision, partner service

contributions, core services to be delivered and relationship and communication with child welfare partners prior to the opening of the programme. One agency withdrew because it could not agree on the proposed relationship with child welfare.

It has been a challenge to engage pregnant homeless women, and administer treatment maintenance for this group of women.

In general, homelessness and lack of safe, affordable housing continue to present barriers for women with substance use problems in maintaining safety and stability in their environment.

Lessons learned

An outreach programme can increase the engagement rate for pregnant substance-using women, and early identification and engagement (first and second trimesters) result in improved birth outcomes.

The financial efficacy of the partnership model has been demonstrated. The value of the in-kind contributions of the partner organizations exceeds the base funding amount from Health Canada, ensuring the richness and stability of programme services.

The cross-sectoral, integrated partnership model to support pregnant substance-using women and their children has been replicated in a number of communities, and there has been interest in the project across Canada and internationally resulting in knowledge and skills activities and resource development.

The women report significant histories of substance use in their families of origin, resulting in hypotheses that they themselves may be affected by the prenatal substance use of their own mothers. This has raised questions regarding effective practices to support parents who are affected by prenatal substance use.

The importance of embedding diagnostic clinics in the context of community-based treatment and parenting programmes for women who are substance-involved is being demonstrated.

Qualitative and focus group data confirm the significant deleterious impact of substance abuse on parenting and child development.

There is a continuing challenge in bringing together treatment sector and child sector providers in recognizing both the adult and the child as clients.

Czech Republic: A therapeutic community for parenting women

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Status: non-governmental organization receiving government and private funding; years of operation: 3

Background

SANANIM runs a full continuum of care for people with substance use problems in the Czech Republic. It includes a contact centre, two therapeutic community programmes, outpatient programming and an aftercare centre. At the time that the Therapeutic Community Karlov was established, there were no substance abuse treatment programmes for pregnant and parenting women in the Czech Republic. However, an increasing number of women with children were being seen at SANANIM's low-threshold programme, and information collected from SANANIM's various other programmes indicated the need to build a specialized programme. A therapeutic community is an accepted type of treatment in the Czech Republic and is supported within the framework of the national drug strategy demand reduction component.

Objective

The objective is to provide treatment for women with substance use problems who are pregnant or have children.

Activities

Treatment programme: The programme operates as a therapeutic community and has a capacity to serve 10 mothers and 12 children. The average length of stay is 10 months. The programme also accepts pregnant women. In addition to the Therapeutic Community, SANANIM provides an outpatient programme and an aftercare programme with sheltered housing for pregnant and parenting women. One part of the programme involves parenting skills, and SANANIM has two specialized staff who work with the women to help them acquire these skills.

Clients: The Therapeutic Community Karlov serves two groups, each with their own separate building. These

two groups are women 18 years and older with children and young people between 16 and 22 years of age.

Awareness and networking: SANANIM is active in networking with programmes and institutions in contact with pregnant and parenting women who use substances. It also tries to enhance awareness about its services for this target group.

Results/accomplishments

A need for the programme has been established over the five-year running period. Clients have been successful in completing treatment, reintegrating into normal life and caring for their children. The programme is becoming better known among other institutions in the Czech Republic, and networks are slowly being built. The programme has established good cooperation with the justice system, which recognizes the SANANIM programme. Through this, a mother who has fulfilled her treatment conditions can legally maintain or retain custody of her child.

Challenges

At the system level, the main challenges are the attitudes and actions of those in contact with substance-using pregnant women, where the mother frequently loses custody of her infant immediately after birth.

At the programme level, some major challenges are:

- Helping women who are mothers develop motivation to stop using substances and also to support women in their role as mothers;
- Working with the women's partners who are also generally substance users;
- Revitalizing the family system in order to ensure support at home, and parental help when women leave the Therapeutic Community; often these relationships have been badly damaged during a woman's substance use; and
- Balancing the need to address substance use and the need to provide support, education and parenting skills.

Lessons learned

There is increased recognition of the need for a gender-specific programme and the need to develop a greater capacity to serve pregnant and parenting women in the Czech Republic.

India: Detoxification and counselling for women with children

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Status: non-governmental organization; currently bridge funding available; years of operation: 9

Background

Since the first female client sought treatment 17 years ago, the number of women seeking treatment has increased consistently. Major difficulties emerged, however, because men and women were living under the same roof, and there were no services for women with substance use problems, no programme designed to address the specific needs of substance-dependent women and their children and no holistic services available to substance users that treated the entire family, and women substance users were greatly stigmatized and vulnerable to sexual and physical abuse. Trafficking in women and children affected by substance abuse was also a problem. Thus, it was recognized that there were complex gender issues needing an entirely new system, designed specifically for women and children.

Objectives

Objectives include to provide an enabling environment to chemical-dependent women and their children; to empower women by making them aware of their rights and encouraging them to make independent decisions; to provide an effective model of substance abuse treatment services for chemical-dependent women, basic medical care and referral services; and to address areas of negative socio-economic consequences through culturally appropriate social and economic reintegration and drug education programmes; and to provide gender-sensitive residential care and rehabilitation programmes, designed to suit individual needs.

Other objectives are to help women develop marketable skills and provide residential support, client management and continuing care to enable women to reintegrate with family networks and mainstream society; and finally, to provide awareness about HIV/AIDS and other blood-borne infections.

Activities

Start-up: Initially, local resource mobilization provided the financial support necessary until formal funding was obtained from agencies funding other Sahara projects. Human resources were obtained by using experienced staff from Sahara's substance abuse treatment programme for men; later, former clients from the substance abuse programme for women became staff members.

Treatment programme: The programme design has evolved over the years through experience and according to need. Currently the main types of services provided to women are: detoxification, counselling, therapeutic activities, awareness and education, skill building, adult literacy, vocational training and guidance, job placement services, health care (e.g. immunization), crèche facilities, peer group support services for people living with HIV/AIDS, supplementary nutrition for people living with HIV/AIDS, children's literacy (informal education) and nutrition programme, support services for ex-clients, family counselling, Midway Home and referrals.

For pregnant women, Sahara House provides prescribed supplementary diet and nutrition, awareness and education sessions related to pregnancy and parenting, health-care referral services (regular check-ups) and an immunization programme.

Recently Sahara House has also introduced a day facility for clients who are unable to participate in a rehabilitation programme due to family constraints. This day facility is also designed for women who have completed the rehabilitation phase but access the day service while they are looking for a job.

Clients: The clients of Sahara House are aged 16 years and older. Children of all ages and both genders are served. The types of substances used by the women include heroin, buprenorphine, Spasmo proxyvon (which contains a synthetic opioid used as an analgesic), marijuana, opiate-based cough syrups, cocaine, alcohol and sedatives.

Staffing: Graduates of the programme provide most of the staffing, as well as empowered women who serve as role models and provide guidance.

Results/accomplishments

Since its beginning, Sahara House has successfully networked for resources and medical referrals and created a

flexible programme and used a client-centred approach, facilitating clients' motivation to make and maintain behavioural changes. As well, the local community members access the crèche and the literacy programme, thereby encouraging community development.

Ex-substance users who are sensitive to the issues faced by clients work at the centre, and these empowered women act as role models for clients. After treatment, clients are empowered and independent and have been rehabilitated and successfully relocated in Delhi.

A short stay in Midway Home is available for the final stages of the reintegration process.

A platform has been created where the voices of women using substances can be heard. Over 400 clients have directly benefited from Sahara House, and more than 2,000 have been undocumented.

The project has observed a marked improvement in the health status and awareness of both women and children, and children are being initiated into the educational system.

The project has undertaken drug awareness programmes such as street plays, the distribution of materials and drug awareness activities in schools, and has supported advocacy activities for policy changes regarding women through membership in network organizations in order to overcome stigma and attitudes to women substance users.

Challenges

With regard to children, the following challenges were faced: obtaining medical care for women and their children, including medically supervised withdrawal for breastfed infants, due to the strong social stigma attached to women with substance use problems. This has been overcome by persistence, until non-judgemental medical personnel willing to treat women were found; obtaining childcare, especially for young children, while their mothers were in detoxification or attending treatment, which was overcome by initiating the crèche facility; obtaining provisions and basic amenities for children (e.g. adequate number of toilets designed for younger children, and baby food), which was resolved by revising budgets and mobilizing funds.

Additionally, family interference with women clients was a problem because family members were insensitive to the time that was required for treatment. This has been

resolved through family counselling and maintaining confidentiality about women seeking treatment. Lack of family and financial support led to added costs for Sahara House.

Women are sometimes sexually abused by their family members and refuse to seek help from the family, which leaves them without support. This can be addressed by encouraging women to be independent and giving them specific goals.

Other challenges arose, such as insufficient services and self-support groups for women; women clients desiring male relationships, which resulted in strict rules for male staff members about not getting involved with women clients; lack of individual awareness of legal and human rights; and pregnant, often malnourished, women coming for treatment late in their pregnancies (e.g. after the supplementary nutrition and prescribed diets would have been effective).

A number of barriers to treatment access experienced by women still exist and need to be addressed. There is still a lack of knowledge about substance abuse and available treatment and women substance users are still highly discriminated against. Women and their families shy away from trying to find out about available treatment because of the extreme social stigma. Women are faced with social responsibilities, which makes it difficult for them to access long-term residential treatment. Also, for women who are involved in the sex trade it is difficult to break away from brothel owners and pimps.

Lessons learned

Due to the stigma and discrimination attached to women substance users they are a “hidden population”. This is closely linked to the oppression of women in every form and element of society, which seems to be an underlying factor influencing substance use.

Women affected by substance use problems have other complex issues that need to be addressed such as poverty, child marriage, sexual abuse, violence, sex work, trafficking in women, abandoned and deserted women (mainly due to disclosure of their HIV status), stigma and discrimination.

Finally, because women are unaware of their legal rights, they accept situations as being part of their life and are conditioned to believe that they should be subservient to their men, their families and society.

Panama: Residential treatment for women

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Status: non-governmental organization supported by time-limited fund-raising from national and international organizations; years of operation: 20

Background

Teen Challenge has been working for the last 24 years with people with substance abuse problems all over the country, but for many years services were only provided to men. Due to the increasing number of women with substance use problems, a decision was made to create a treatment centre for women.

Objectives

Objectives are to provide assistance to Panamanian women affected by substance use problems; to facilitate social reintegration of recovered women following treatment.

Activities

Start-up: The project plan was based on the collection of statistical information about substance abuse.

Treatment programme: The programme serves only women from any part of Panama, but principally from Panama City. It provides medium- and long-term residential treatment. The treatment approaches include spiritual therapy, combined with work-related therapy/occupational therapy and ludotherapy—a form of play therapy, and psychiatric and psychological treatment if required. These different approaches are integrated. The programme accepts pregnant women, and provides prenatal care in collaboration with health centres that have a visiting gynaecologist. Women with children are also accepted and are provided with special accommodation so they can stay together. Pregnant and parenting women participate in the same treatment as other women.

Clients: Clients are adult women, 18 years of age and over, with substance abuse problems, involving both licit and illicit substances.

Results/accomplishments

Accomplishments include the rehabilitation of many Panamanian women, some of whom are mothers. Many are now working and can provide their children with good homes. The centre achieves rates of recovery similar to women's centres elsewhere in Panama and in other countries.

Challenges

Challenges include lack of resources. More funds are required to improve the physical environment of the treatment centre (furniture and other requisites), particularly for pregnant women and women with children; transportation; and supply medicines (vitamins) for women patients. Though the organization has been trying to address these gaps through fund-raising, it has not been totally successful. Women may have to wait to access this women-only programme.

Lessons learned

Substance abuse problems are not just a male problem; they also affect women, mainly young women. There is a need to increase the enrolment of women in treatment, to create new treatment programmes and to increase activities to prevent substance use problems from starting at an early age.

The success of this project is mainly due to the devotion of the staff involved.

United States: A medication-assisted, outpatient and residential programme for pregnant women

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Status: non-governmental organization, with ongoing funding; years of operation: 29 years for the outpatient, 12 years for the residential programme

Background

Maternal Addiction Treatment, Education and Research (MATER) is a women-only programme whose out-

patient programme was developed in 1974 as part of a National Institute on Drug Abuse (NIDA) research demonstration grant as a model to provide comprehensive services to pregnant opioid-dependent women. At that time, few if any programmes existed in the country. Although there has been an emphasis on programmes for women and children within the last 15 years in the United States, there are still few programmes that specialize in pregnant women. The residential programme was developed in 1989, also as part of a NIDA research demonstration grant, to assess the effectiveness of residential treatment for cocaine-abusing, pregnant women. At that time, it was a challenge for treatment programmes to successfully engage cocaine-abusing, pregnant women in treatment with the consequence of poor perinatal outcomes.

Objectives

The objectives are to improve and sustain the health and safety of women and their children and the communities they represent by providing:

- State-of-the-art women-centred, medication-assisted treatment;
- Comprehensive, compassionate, efficient, quality addiction treatment for pregnant and/or parenting women; and
- Affordable addiction treatment, using a public health model, through the provision of medication-assisted treatment, individual and group counselling, family therapy and services, parenting education, relapse prevention education, prenatal care, education on women's health issues and case management services.

Activities

Programme start-up: The programme used local and national data, which provided documentation of the need and utilized clinical knowledge and research data to develop a model that would meet the needs of the women. Initial resources were provided by grant funding, and subsequent resources have been obtained through multiple funding streams.

Treatment programme: MATER provides specialized comprehensive services through two treatment modalities—intensive outpatient with a capacity for 170 women, and residential with a capacity for 20 women and their children under six years of age—the programme usually has 20-30 children. Services include individual and group counselling, medication-assisted treatment, HIV

counselling and testing, psychiatric services, prenatal/obstetrical care, case management and parent-child services. The programme is evidence-based (based on MATER research and the research of others).

Perinatal care is provided by perinatologists who work directly with the programme and who understand addictions. Weekly prenatal and health education groups are conducted by the nurse coordinator. Parent-child services are provided by parenting staff trained in early childhood education. MATER has parent-child centres in both the outpatient and residential programmes, which provide developmental childcare; parent child specialists conduct parenting groups including didactic and experiential groups with mother and child; and quarterly field trips are conducted for mothers and their children. Although all components of the programme are successful because they have evolved from assessing utilization and retention rates, the most visibly successful components are prenatal and parenting services.

Clients: Pregnant and parenting women with an average age of 29 years and a range of 18-45 years. Approximately 15 per cent of the women are Latina, 40 per cent African-American and 45 per cent Caucasian. Over 95 per cent of the women abuse heroin. For the 5 per cent non-heroin users, cocaine is the primary drug of abuse, in addition to marijuana and alcohol. A large percentage of the heroin users also abuse cocaine, benzodiazepines and marijuana. A majority of the women have been physically and/or sexually abused as children and as adults, are single heads of households and suffer from additional psychiatric problems. The programme serves the entire Philadelphia metropolitan area.

Results/accomplishments

Through MATER, high-risk women are able to deliver full-term healthy newborns and rebuild their lives so that they can provide a healthy environment for both themselves and their children. Success is measured by birth outcomes and by the progress that women make rebuilding their lives. A study of treatment outcomes for the MATER programme found that women in residential treatment averaged 6.3 months in treatment and women in outpatient treatment 5.8 months. Both groups who remained in treatment achieved high rates of abstinence (97 per cent in residential treatment versus 47 per cent in outpatient treatment). The proportion of pre-term or low-birth-weight infants born to mothers who were followed to delivery, compared favourably with national norms. In almost all cases, infants were discharged from hospital to the care of their mothers [53-55].

Challenges

The population served by MATER is particularly difficult to work with because of the multifaceted issues that must be addressed. This is made more difficult by the lack of national political/social commitment to women and children, the prejudicial and pejorative attitude towards this population and the lack of resources to provide the necessary services, such as sufficient funds to meet the demand for residential treatment or to pay for ancillary services.

Lessons learned

This special population requires extensive specialized services. We also learned that when such services are provided in a safe, supportive environment, both maternal and neonatal morbidity and mortality can be significantly reduced, and the women's improvement in life functioning will benefit themselves, their families and the community.

Recommendations for successful approaches and lessons learned

The following recommendations regarding successful approaches and lessons learned reflect the literature review, case studies and discussions at the Vienna meeting:

- *Involve key community stakeholders and services and systems.* The literature and the experience of case study projects demonstrate that successfully establishing substance abuse treatment services for women requires the support of community leaders, including those who control funding, as well as a range of community stakeholders and service systems.
- *Apply evidence-based treatment interventions in the context of systematic project planning and development.* Evidence-based treatment interventions that are based on systematic project planning and development should be applied, including a systematic needs assessment. In order to ensure long-term sustainability, programmes should be developed based on available resources. It is better to start as a smaller project and expand as sustainable resources become available.
- *Incorporate programme monitoring, evaluation and research activities.* The need for increased information about women with substance use problems and effective interventions has been noted in the literature. In addition, a number of the case study projects

have a strong evaluation and research base and have been able to demonstrate the impact of programming on client outcomes, which not only furthers knowledge about successful women's programming but also provides documentation important for continued programme funding. Programmes should be encouraged to routinely incorporate monitoring and evaluation activities.

- *Undertake research on treatment methods for different population groups.* Discussions at the Vienna meeting noted that more research is required on treatment methods for different populations of women such as those who use cocaine/crack, and on treatment methods for pregnant women dependent on substances, particularly in countries where opioid substitution treatment is not authorized.
- *Employ culturally appropriate, community-based programming strategies.* The case studies have demonstrated the importance of adapting effective interventions that take into account differences in culture, language, life situation and social roles of women. Community-based, outpatient programming is a successful approach, particularly in regions where it is difficult for women to leave their communities.
- *Employ a range of staff, including some that reflect the population of women being served.* The literature, as well as the discussions at the Vienna meeting, has recognized the importance of employing staff with a range of backgrounds who share some characteristics with clients so they can be role models for clients. If male staff are employed, their role should not jeopardize the physical and psychological safety of women clients.
- *Provide training and supervision.* The literature, as well as the discussions at the Vienna meeting, has emphasized the importance of providing staff with training and supervision. Services should endeavour to have staff with competencies in crisis intervention, trauma counselling and concurrent disorders, as well as vocational and social integration training skills.
- *Address social reintegration issues.* The literature, case studies and the discussions at the Vienna meeting indicate that women have fewer resources and supports than men and need assistance to develop economic self-sufficiency, safe housing and a social support system. Discussion in the working groups at the Vienna meeting identified that social reintegration is more complicated for women.
- *Develop collaborative relationships and agreements with other services and systems.* The case studies, in particular, demonstrate some of the difficulties experienced by clients and programmes in obtaining required services and the need to have good working relationships with related systems, particularly the child welfare system, prenatal care services and mental health system, as well as systems providing practical resources such as housing.
- *Offer comprehensive programming that acknowledges gender differences and responds to women's different needs.* Both the literature and the case studies indicate that women with substance use problems have complex and multiple needs that are different from those of men. They also demonstrate that the provision of comprehensive care including women-only services, prenatal and childcare, parenting skills, relationships, attention to mental health problems and attention to practical needs can improve treatment retention and outcomes for women. The Vienna meeting discussions noted that treatment retention is enhanced by a friendly environment, flexible opening hours, childcare, transportation and optional therapy for couples.
- *Address trauma and concurrent disorders.* The literature and case studies indicate that high rates of trauma and concurrent mental health problems are very common among women with substance use problems, and they require an integrated treatment response. The discussions at the Vienna meeting noted that successful approaches included seconding staff from services that deal with acute trauma to substance abuse treatment services, ensuring "quality control" in the assessment of trauma issues, accepting and acknowledging the issue for clients, respecting confidentiality and not pressuring women to reveal trauma.
- *Provide opioid substitution treatment in the context of other components of comprehensive care.* The literature indicates the effectiveness of opioid substitution treatment, particularly involving methadone, in reducing illicit substance use and related consequences, and for use with pregnant, opioid-dependent women. However, for women, opioid substitution treatment needs to be provided in the context of comprehensive and coordinated care that addresses medical, psychosocial and practical issues in women's lives. To ensure access to opioid substitution treatment, issues such as flexible hours, childcare, transportation and safety need to be taken into account.
- *Provide comprehensive and coordinated care for pregnant and parenting women.* The literature and case study projects demonstrate that providing care for

pregnant, substance-using women that is multidisciplinary, comprehensive, practical, and offered through a single access point contributes to improved retention and outcomes for mothers and newborns. Discussion at the Vienna meeting identified successful approaches to be those including: pre-treatment motivation programmes, activities that promote bonding between mother and unborn child and motivate women to consider their own longer-term health needs, not just the health of the baby; family planning; and awareness and attitude training for pre- and post-natal care providers. Support for mother and child to stay together such as mother/child units in residential care, and good supervision and training in self-care skills for staff who work with pregnant, substance-using women. Harm reduction models for pregnant and parenting women who are still using were also identified as being important.

- *Provide opioid substitution treatment for opioid-dependent pregnant women.* Though not all countries allow methadone or other opioid substitution drugs to be prescribed, it is the treatment of choice for pregnant or breastfeeding women dependent on opioids. The discussions at the Vienna meeting underlined the need to develop guidelines for treatment of opioid-dependent women in countries where substitution drugs are not authorized, as well as for the treatment of pregnant women using psycho-stimulants.

Key points

The key points in chapter 5 are as follows:

- Programme planning and development should be based on a careful needs assessment, with mechanisms built in to monitor achievement of programme and client objectives and outcomes.
- Successfully establishing a programme for women requires the involvement of key stakeholders who can provide initial and ongoing support for the programme, especially in times of limited resources.
- Gender-responsive programme organization addresses the structure of women's services, the involvement of women staff in leadership roles, ensuring that the environment is safe for women clients, and the employment, supervision and training of staff, some of whom should share some characteristics with clients and be role models.
- Community-based, culturally appropriate, outpatient or day treatment, located close to where women live, increases access and is less costly. However, some women, because of the severity of their substance use and related problems or other circumstances, will require residential treatment.
- Aftercare and social reintegration components, including activities that address skills development, employment and housing, are critical components of treatment for women.
- A comprehensive assessment should address areas particularly relevant for women, such as relationships, pregnancy, mental health problems including suicide, history of abuse and current domestic violence.
- Programmes for women should be gender-responsive in their philosophy and principles, with an integrated theory that provides a framework for programme development, content and materials. Providing women-only programmes that employ male models of treatment using labelling and confrontation will not produce desirable treatment outcomes for women.
- Studies have found that comprehensive or enhanced programming, which includes components such as women-only groups, childcare, prenatal care, women-focused topics, mental health programming, produces better outcomes for women in comparison with traditional mixed-gender programmes.
- Cognitive and behavioural treatment approaches have received scientific and clinical support for use in treatment programming for women.
- Recent work on women's psychological development has recognized the central role of relationships and connectedness in women's lives. Helping women learn ways to develop and maintain healthy relationships, women-only groups, family education and therapy, on-site childcare and parenting skills training are mechanisms to support women's need for connectedness and their network of relationships.
- The experience of trauma and mental health problems are common among women with substance use problems. Services for women need to be aware of the impact of these problems and develop strategies to address these issues either on site or through referral.
- Pharmacological interventions for opioid dependence, particularly for pregnant, opioid-dependent women, can reduce illicit substance use and related problems, improve social functioning and result in

better outcomes for newborns of pregnant women. However, pharmacological interventions need to be offered in the context of providing gender-responsive psychosocial treatments and addressing other practical needs.

- Pregnant and parenting women have unique needs that require approaches that are non-judgemental, comprehensive and coordinated, particularly involving coordination between substance abuse treatment services and the child welfare and prenatal care sectors.

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