Women's Health Issues 25-6 (2015) 666–672

WOMEN'S HEALTH ISSUES
www.whijournal.com

Original article

Special Services for Women in Substance Use Disorders Treatment: How Does the Department of Veterans Affairs Compare with Other Providers?

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Article history: Received 8 October 2014; Received in revised form 21 May 2015; Accepted 6 July 2015

A B S T R A C T

Background: Gender is an important consideration in the treatment of substance use disorders (SUD). Although the number of women seeking care through the Department of Veterans Affairs (VA) has increased dramatically, little is known about the capacity of the VA to meet the needs of women with SUD. We examined the prevalence of programs and key services for women in VA facilities in a survey of 14,311 SUD treatment facilities.
Methods: Using data from the 2012 National Survey of Substance Abuse Treatment Services, we calculated the percent of VA facilities offering special programs or groups exclusively for women, compared with facilities under other types of ownership. For each ownership type, we also calculated the mean number of ancillary services offered that are critical for many women in SUD treatment, including child care, domestic violence counseling, and transportation assistance. Multivariable models were used to adjust for differences in other facility characteristics.
Findings: Approximately 31% of facilities had special programs exclusively for women. The VA had the lowest prevalence of programs for women, at 19.1%; however, the VA offered an average of 5 key services for women, which was significantly higher than the averages for other federal ($n = 2$), local ($n = 4$), and private for-profit ($n = 2$) facilities. Results were generally robust to multivariable adjustments.
Conclusions: The VA should consider developing more SUD programs and groups exclusively for women, while maintaining ancillary services at their relatively abundant level. Gender-specific programs and groups could serve as points of referral to ancillary services for women veterans.
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A fundamental approach to improving the quality of behavioral health care has been through the establishment of special programs that focus on clients with unique treatment needs (Institute of Medicine, 2006). Women with substance use disorders (SUD) have treatment needs that are different in many ways from those of men (Substance Abuse and Mental Health Services Administration [SAMHSA], 2009). Although there is no universally accepted definition of gender-specific SUD care for women, it generally refers to ancillary services that facilitate access to care (e.g., transportation, child care), services that are specific to the needs of women (e.g., prenatal care, trauma counseling for women), or women-only treatment programs (Brady & Ashley, 2005). Recent reviews suggest that programs that address the special needs of women with SUD are more effective than those that do not (Ashley, Marsden, & Brady, 2003; Brady & Ashley, 2005; Greenfield, et al., 2007). For example, an evaluation of an enhanced SUD program exclusively for women with children showed that clients who used available child care and transportation assistance subsequently used a greater number of health and social services, which was in turn associated with decreased substance use (Marsh, D'Aunno, & Smith, 2000).

The prevalence of SUDs and the demand for SUD treatment among women veterans has increased substantially in recent

Funding statement: This research was conducted while Kevin Heslin was a research health scientist at the Veterans Health Administration. We acknowledge the support of this research by the Office of Public Health, Veterans Health Administration, Department of Veterans Affairs. The funder played no role in the design or conduct of the study, the collection, management, analysis, or interpretation of the data, or the preparation, review, or approval of the manuscript.

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1049-3867/$ - see front matter Published by Elsevier Inc. on behalf of the Jacobs Institute of Women's Health.
http://dx.doi.org/10.1016/j.whi.2015.07.005

years. From 2005 to 2010, there was an 81% increase in SUD diagnoses among women receiving care at the Department of Veterans Affairs (VA), compared with a 33% increase among men (Cucciare, Simpson, Hoggatt, Gifford, & Timko, 2013). Further, women who use mental health/SUD care through the VA do so to a greater extent than do men. In 2009, 38% of women VA patients used any mental health/SUD care, compared with 26% of men, and a greater proportion of women used these services six times or more (Frayne et al., 2012). If growth continues, increasing demands on VA delivery systems for women with SUD are anticipated.

Organizational policies have the potential to spur innovations in care for women with SUD, but factors such as the type of ownership under which organizations operate are likely to affect program development. Across a number of studies of SUD treatment providers outside of the VA, ownership status has been one of the factors most consistently associated with the presence of gender-specific care for women. In a representative sample of outpatient SUD treatment providers in the United States, private for-profit providers were less likely than public sector providers to offer same-gender group counseling (Alexander, Nahra, Lemak, Pollack, & Campbell, 2007), domestic violence counseling (Campbell & Alexander, 2006), prenatal care, and child care (Campbell et al., 2007). Olmstead and Sindelar (2004) analyzed data on a national sample of SUD treatment providers to examine the prevalence of programs targeting several special populations, including women. They found that private nonprofit and public sector providers were more likely than private for-profit providers to offer services pertaining to child care, domestic violence, and other issues that are common among women in SUD treatment.

Although nearly one-half of public funding for SUD care in the United States comes from federal sources (Mark, Levit, Vandivort-Warren, Buck, & Coffey, 2011), federal providers have been excluded from these and other important studies of the relationship between organizational factors and tailored SUD care for women, thus impeding any comparison of the availability of programs for women between the VA and other SUD treatment providers (Campbell & Alexander, 2006; Campbell, Alexander, & Harris Lemak, 2009; Olmstead & Sindelar, 2004). Further, some of the most extensive work on SUD care for women has been limited to the outpatient setting, even though hospitalization is a critical component of the SUD continuum of care (Campbell & Alexander, 2006; Campbell, Alexander, & Harris Lemak, 2009). Given the growing number of women veterans using VA services for SUD, it is important to examine the extent to which special programs and key services for women are available within the VA. In this article, the term "program" is used to refer to an SUD intervention designed exclusively for women; by contrast, the term "key services" refers to childcare, domestic violence counseling, transportation, and other ancillary services that have been recommended by SAMHSA (2009) as important for women in SUD treatment (but which could also be provided to men). Information about the availability of gender-specific SUD programs and key services could assist policy makers and planners in current initiatives to make the VA system more responsive to the treatment needs and preferences of women veterans. Using data on a national sample of SUD treatment providers, this study compares the prevalence of gender-specific programs and key services for women in the VA system with other federal, state, local, tribal, private nonprofit, and private for-profit providers.

Methods

Data were obtained from the 2012 National Survey of Substance Abuse Treatment Services (N-SSATS), a cross-sectional survey of all public and private facilities in the United States that provide SUD care. The survey collected questionnaire data on the characteristics of facilities with a reference date of March 30, 2012. The sample size for the public use dataset is 14,311 (89% of 16,114 eligible facilities). The questionnaire covered a range of topics including client characteristics, services offered, standard operating procedures, and treatment capacity. Data were collected using three modes: web-based questionnaire, mailed paper questionnaire, and structured telephone interview. Full details about the N-SSATS methods are available elsewhere (SAMHSA, 2013). These analyses were exempted from review by the Institutional Review Board at the VA Greater Los Angeles Healthcare System.

Dependent Variables

This analysis focused on two dependent variables: a dichotomous variable indicating whether the facility offered a special program or group exclusively for women, and a count variable (0–8) representing key ancillary services that have been recommended by SAMHSA (2009) as important for women in SUD treatment. Data for the first dependent variable were collected with a questionnaire item that listed 14 client populations, with respondents checking a yes/no box for each population to indicate whether their facility offered "a specially designed substance abuse treatment program or group exclusively for that type of client." For the current study, responses regarding the client population of "adult women" were used for the dichotomous dependent variable on special programs or groups exclusively for women. Data for the second dependent variable were collected with an item that listed 19 ancillary services, each with a check box for respondents to indicate whether their facilities offered that service. After coding responses as equal to 1 if the service was offered and 0 if otherwise, a count variable ranging from 0 to 8 was created by summing responses across the following eight key services: childcare; domestic violence services; trauma counseling; assistance obtaining social services such as the Special Supplemental Nutrition Assistance Program for Women, Infants, and Children (WIC); employment assistance; housing assistance; transportation; and residential beds for children. Previous research on SUD treatment for women has studied a number of these key services (Marsh et al., 2000; Olmstead & Sindelar, 2004; Oser, Knudsen, Staton-Tindall, & Leukefeld, 2009).

Independent Variables

The main independent variable in this analysis is facility ownership, which had the following seven categories: VA, other federal (including the Department of Defense and Indian Health Service), state, local, tribal, private nonprofit, and private for-profit.

As with previous work examining the availability of gender-specific care within the VA (Yano, Goldzweig, Canelo, & Washington, 2006), the literature on the diffusion of innovation was helpful in identifying variables related to size, scope of services, complexity, and resources to include in the analysis (Rogers, 2003). Because larger organizations may have more resources to provide gender-specific care, we included a