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Does gender-specific substance abuse treatment for women promote continuity of care?

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Abstract

Research has stressed the value of providing specialized services to women and suggests the importance of treatment duration. This quasi-experimental retrospective study reports on the continuity of care for women with children who were admitted to long-term residential substance abuse treatment. Women were admitted to 7 agencies offering specialized, women's only treatment (SP, $n = 747$) or to 9 agencies that provided standard mixed-gender treatment (ST, $n = 823$). Client and treatment data were gathered from administrative sources. We hypothesized that women in specialized treatment would demonstrate higher continuing care rates after controlling for treatment completion and length of stay. Women in SP programs (37%) were more likely than those in ST programs (14%) to continue care. Multivariate analyses revealed that SP clients who completed treatment with longer stays were most likely to continue care. The findings show that specialized treatment for women promotes continuing care and demonstrate the importance of treatment completion.

Keywords: Gender-specific treatment; Women; Substance abuse; Continuing care; Treatment completion

1. Introduction

In the past two decades, gender-specific services emerged in response to the multidimensional profile of problems that women display upon admission to substance abuse treatment. The emergence of women-only treatment programs also reflects the recognition that traditional mixed-sex programs often fail to address women's needs, and programs designed specifically for parenting women have been developed to address the additional needs faced by mothers and their children. Treatment models for women have become more prevalent within the field, but limited research has been conducted to examine whether women receiving treatment from women-only programs differ in their characteristics and treatment outcomes from women receiving treatment from mixed-sex programs (Grella, 1999). There is mounting evidence that women admitted to women-only programs have better retention and better outcomes relative to traditional mixed-gender programs. However, most women in the United States are treated in nonspecialized mixed-gender settings, and little empirical research has measured the degree to which gender-specific programming is related to treatment outcomes. Although there are a handful of small-scale studies that looked at policy-relevant client outcomes—and some larger-scale studies that looked at program costs or retention—there have been no large-scale comparative studies on whether specialized programs that address parenting women's needs lead to better outcomes compared to more traditional approaches; on program characteristics that are associated

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with successful outcomes; and on whether these outcomes offset the costs of providing specialized services.

1.1. Gender-specific treatment

Although much of the research on gender-sensitive treatment has examined services intended to meet women's distinctive treatment needs, theoretical models that focus on addiction and recovery for women have also emerged in recent years (Velasquez & Stotts, 2003). Recent gender-sensitive theoretical models view substance abuse in the context of women's relationships, including broader relational and multigenerational systems. Women's addiction has been described as more "socially embedded" than men's (Saunders, Baily, Phillips, & Allsop, 1993). Similarly, qualitative studies concerned with women's recovery hinge on the repair of relationships with children and other family members and on the development of support systems to prevent relapse (Kearney, 1998; Lewis, 2004).

Many women entering treatment have experienced violence, including child abuse, battering, or rape, which affects subsequent connections with others. These relationship "disconnections" may be associated with addiction, although, conversely, treatment services that build "connections" may be associated with women's recovery (Comfort & Kaltenbach, 2000; Finkelstein, 1994). Because women entering treatment report social isolation, are more likely to have partners who are involved in drugs or alcohol, and have fewer friends than their male counterparts, family therapy approaches have been utilized (McComish, Greenberg, Ager, Chruscial, & Laken, 2000; McComish et al., 2003). Finally, the use of a relational model is consistent with a recent call to examine treatment outcomes as related to gender role and culture, rather than as related to gender per se (Hodgson & John, 2004).

For parenting women and their children, several issues suggest a need for deviation from traditional models. Some traditional program models (e.g., therapeutic communities) tend to use a confrontational style that does not work with most women (Kauffman, Dore, & Nelson-Zlupko, 1995). Furthermore, women may benefit from a style of treatment that is less structured and less rigid (Hodgins, el-Guebaly, & Addington, 1997). Programs have historically been predominantly for men, and "male cultural norms" have dominated (Hodgins et al., 1997; Saunders et al., 1993). The recognition of interpersonal group dynamic communication is more important in the treatment of women. For example, women tend to be more expressive verbally and behaviorally in single-sex group sessions, and often yield to both women and men when interrupted in mixed-gender settings, whereas men tend to only yield to interruptions from other men (Hodgins et al., 1997). For women in such groups, issues left unaddressed can result in adverse psychological effects (Copeland & Hall, 1992). Women stress that a treatment environment that is safe for themselves and their children promotes therapeutic effects (Lewis, 2004). Other environmental characteristics, such as comfort, size, privacy, location, and attractiveness, have a small but demonstrable influence on women's engagement in treatment (Grosenick & Hatmaker, 2000).

The ability of a substance-abusing mother to be accompanied by her child while on treatment is characteristic of specialized treatment. Although some have argued that children in a treatment facility distract a mother's ability to "work her program" (thus delaying or adversely affecting her recovery), available evidence suggests that women who are allowed this provision demonstrate higher rates of retention (Chen et al., 2004; Coletti et al., 1992; Hughes et al., 1995). Treatment for women and their children necessitates an emphasis on a "family context," which provides for an enhanced interaction between mother and child and an enhanced quality of family/domestic environment (Washington State Department of Social and Health Services, 1999). Trauma histories are common among female substance abusers and must be addressed appropriately in treatment (Orwin, Maranda, & Brady, 2001). Other general recommendations for achieving successful outcomes among women, especially those with children, include a continuum of coordinated and family-focused services and interventions guided by female-specific substance abuse treatment models (McKay, Gutman, McLellan, Lynch, & Ketterlinus, 2003; Washington State Department of Social and Health Services, 1999). Importantly, the delivery of childcare and prenatal care, a focus on women's topics, comprehensive programming, and the utilization of supplemental services have been found to differentiate specialized and traditional treatments and are positively associated with treatment completion, length of stay (LOS), and improved treatment outcomes (Ashley, Marsden, & Brady, 2003).

The complex patterns and intricate interdependence of women's substance abuse problems and outcomes support the need to identify gender-sensitive factors to address these issues (Green, Polen, Lynch, Dickinson, & Bennett, 2004). Relative to traditional mixed-gender programs, evidence exists that women in women-only programs have better retention (Anglin, Hser, & Grella, 1997; Washington State DSHS, 1999) and better treatment outcomes (Orwin, Francisco, & Bernichon, 2001; Orwin, Kissin, & Dugan, 2003). The vast majority of women, however, are served in mixed-gender programs (Grella & Greenwell, 2004). The growth of women-only programs in the early to mid 1990s—in part triggered by the "crack babies" scare of the mid 1980s—peaked and was actually in decline by the end of the century (Grella, 1999; Grella & Greenwell, 2004).

1.2. Continuity of care

In recent years, the need to provide a continuum of care to individuals with substance abuse problems has received increasing emphasis. By transferring clients to less restric-