Evaluation of a Specialist Drug & Alcohol Treatment Service for Women: Jarrah House

Jan Copeland, Wayne Hall, Peter Didcott & Vicki Biggs

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PREFACE

The regeneration of the women's movement in Australia in the early 1970s placed issues such as equal pay, equal opportunity, women's health concerns, and social equity on the political agenda.[1] Part of this revival was the development of the Women's Health Movement which argued that the existing health care system was not meeting the needs of many women and that women would not be able to control their lives unless they had control of their bodies.[2] The guiding principles of the Women's Health Movement included the empowerment of women, a social view of health in which all factors that affect health were considered, equity of access to health services and the provision of services which women saw as appropriate to their needs.[3]

The field of addiction attracted the attention of the women's health movement comparatively late in comparison with other areas of health that were perceived to be more relevant to women, namely, abortion, breast cancer, childbirth, contraception, depression and reproductive technologies. When attention focused on addiction, two main criticisms were made of existing drug and alcohol services for women. First, that these services, which primarily catered for males with alcohol and drug dependence, did not address special problems faced by women with drug and alcohol problems. Second, as a consequence women were under-represented in drug and alcohol treatment.

One of the suggested remedies for correcting deficiencies in services for drug and alcohol dependent women was the creation of specialist treatment centres staffed by women to cater solely for women. It was argued that in such a setting, many of the special issues faced by women with drug and alcohol problems, such as sexuality and sexual politics, physical and sexual abuse, and caring for dependent children, could be better dealt with than was the case in the traditional mixed-sex treatment setting.

The provision of specialist womens services was believed to have three major advantages over traditional treatment. First, it would make treatment services more attractive to women with drug and alcohol problems, thereby attracting many women into treatment earlier than would otherwise have been the case. Second, because such programs would be more relevant to womens needs they would retain more women in treatment and produce greater client satisfaction with the treatment that was provided. Third, the greater appropriateness of treatment would ensure a better treatment outcome than would be the case within a traditional mixed-sex treatment setting.

Preface

In 1987, funding was made available for the establishment of a specialist drug and alcohol treatment service for women in Sydney, known as Jarrah House. This monograph is an evaluation of the extent to which Jarrah House achieved the aims of specialist womens services in attracting a broader profile of women with drug and alcohol problems into treatment earlier, retaining them in treatment and improving their outcome after treatment.

The evaluation compares the characteristics of women with drug and alcohol problems who entered Jarrah House and two traditional mixed-sex services over a period of more than a year. It then examines their experiences in treatment, their drug and alcohol use, physical and psychological well-being and social relationships six months after treatment.

The monograph begins with a detailed discussion of the rationale for providing specialist women's alcohol and other drug services. This includes a review of the special treatment needs of women with drug and alcohol problems and a discussion of the available evidence on the under-representation of women in treatment in Australia.

Chapter 2 describes the method used to evaluate the service. It includes a discussion of the research design (a comparative prospective study), the selection of the traditional mixed-sex comparison centres and the way in which treatment process and content were described. The design of a small supplementary study of the client characteristics that predicted treatment drop-out within five days of admission is also presented. A description is provided of the measures of drug and alcohol use, self-esteem, depression and social relationships that were used to assess outcome immediately after treatment, and at six months post-treatment in those women who could be contacted and interviewed.

In the third chapter, a history is given of the establishment and subsequent development of Jarrah House. This information is important in understanding the results of the evaluation, most particularly of the extent to which it proved possible to provide a service that embodied the treatment content and goals of the women responsible for its creation.

Chapters 4 and 5 describe the treatment content and process in Jarrah House and each of the two comparison agencies (respectively). They detail the physical facilities within which each program operated, the admission criteria and process, and the detailed content of the program, namely, its goals, rationale and the ways in which women spent their time.

Chapter 6 presents data on the characteristics of the women who sought treatment in Jarrah House and the two traditional mixed-sex treatment services. This enables an answer to be given to the question: did this specialist womens service succeed in attracting into treatment a clientele different from that which was attracted into the two traditional mixed-sex services? More particularly, did it succeed in attracting women into treatment earlier than did the traditional mixed-sex services?

Chapter 7 describes the results of the 'impact evaluation', that is, the immediate effects of each program on the women who presented to it. This includes a study of treatment drop-out. In addition, a small study was done to assess which client characteristics predicted treatment drop-out, and of whether these predictors differed between the treatment services. The impact evaluation also included an evaluation of the degree of client satisfaction with each program, and of changes in depression and self-esteem between admission and discharge.

Chapter 8 presents information on client outcome at six month follow-up. This includes data on drug and alcohol use, further treatment seeking, involvement in crime, employment status and social stability in the six months since discharge. Some data are also presented on client characteristics that predicted a good or a poor outcome at six months.

In the final chapter, the implications of the study findings are discussed. What do they say about the desirability of providing specialist treatment services for women? What implications do they have for ways in which treatment for women within mixed-sex services could be improved? Finally, the most urgent questions for research and policy development into the special treatment needs of women with drug and alcohol problems are explored.

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CHAPTER 1 The Special Treatment Needs of Women with Alcohol and Other Drug Problems

1.0 Introduction

Feminist critics have argued that existing drug and alcohol services for women have failed to meet the special needs of drug and alcohol dependent women. Such services have primarily catered for drug and alcohol dependent men who constitute the majority of their clientele, and they have, as a consequence, been services for men, largely provided by men, and based upon ideas derived from experience with men who are drug and alcohol dependent. Because of the male bias in their origins and operation, it has been argued that such services fail to address the special needs of women, thus creating major barriers to the treatment of substance dependent women and leading to their under-representation in treatment in comparison with men.

1.1 Are Women and Men With Drug and Alcohol Problems Different?

This question is difficult to answer because the majority of research on drug and alcohol dependence and, indeed, on patterns of non-problematic alcohol and drug use, has been conducted on men. The existing treatment models used with women have largely been developed by and for men, and continue to be refined on the basis of research largely conducted on male subjects. Little consideration has been paid to any psychological and physiological differences between men and women, or to the socio-political context of women's lives. There is, however, enough research evidence to indicate that women and men differ in a variety of ways that may be relevant to the treatment of any drug and alcohol problems they may experience. They appear to differ in the frequency and quantity of drug and alcohol use over their life spans; in their susceptibility to the ill effects of alcohol; the reasons why they become dependent upon psychoactive substances; and in their social and psychological experiences of dependence. All of these may make an important difference to the ways in which men and women who are drug and alcohol dependent can best be assisted to achieve control over their alcohol and drug use.

1.1.1 Lifetime Drinking Patterns

The majority of the available information about patterns of alcohol use in women has been obtained from cross-sectional studies. One of the few longitudinal reports from United States, measured a general population sample from each decade of adult life twice over a period of seven years.[1] They found that the

incidence of drinking patterns that place people at risk for serious problems is higher among men throughout most of the adult life course, although the sex ratio converges in the 30s. On this data it appears that women are most at risk of developing alcohol problems in their 30s, a time when children may be less of a responsibility for many women, and when they may feel the need to re-evaluate the direction of their lives.

A recent Australian study using data from surveys carried out by the Australian Bureau of Statistics in Western Australia, South Australia and New South Wales compared alcohol consumption from 1977 and 1985 (1983 for South Australia). While there was little change reported in the proportion of women who consumed alcohol in the previous week, significant increases occurred in the average daily consumption of women drinkers in all three States. These overall increases reflect increased levels of consumption by younger women aged 18 to 24 since 1977. There was a marked increase in the proportion of younger female drinkers whose average daily consumption reached hazardous levels (as defined by the National Health and Medical Research Council) in all three States.[2] This increase in hazardous levels of alcohol use occurs among young women at the time of greatest social activity and when they are establishing their careers, with the result that these young women may be unwittingly endangering their health by increasing their drinking to keep pace with their male companions.

1.1.2 Physiological Susceptibility

Women appear to be more susceptible to the physical effects of alcohol than are men, a fact reflected in the marked difference in recommended safe levels of alcohol consumption for men and women.[3] This increased susceptibility probably arises for a number of reasons. First, women have a smaller liver and substantially smaller blood volume than men so that concentration of alcohol in their vital organs is higher. Second, this effect is enhanced by the higher ratio of fat to lean tissue in women, as alcohol is relatively insoluble in lean tissue. Third, there are suggestions that women are especially sensitive to liver infection and inflammation, which is possibly due to the action of oestrogen.[4] A further effect of oestrogen is to delay the metabolism of alcohol in women who are taking the oral contraceptive pill.[5] One consequence of these factors is that, for a given dose of alcohol, women achieve a higher blood alcohol level more quickly than men. Women have a more rapid rate of absorption, and the peak blood alcohol level that is achieved is consistently higher than in men. Even when weight differences

are taken into account, women are more likely to become intoxicated at a given dose of alcohol than are men, and this is especially likely in the premenstrual phase.[6]

Another consequence of the sex difference in alcohol absorption and metabolism is the greater vulnerability of women to many of the adverse health effects of alcohol. This is reflected in the overall mortality rate among dependent drinkers. While the death rate among male alcoholics has been reported to be two to three times greater than that of men in the general population, the death rate reported for alcoholic women is 2.7 to 7 times that of women in the general population.[7] Direct comparisons of alcoholic men and women matched on demographic characteristics suggest that excess mortality is more pronounced among alcohol dependent women.[7]

Liver disease is among the specific causes of death to which heavy drinking women seem to be especially susceptible.[8,9] Investigations employing a variety of measures of liver disease, including liver biopsies, death certificates and autopsy reports, have found that women are more likely than men to develop portal cirrhosis with heavy drinking.[10] A case control study of the incidence of liver disorders among 663 male and 137 female alcoholics in Melbourne in 1969 found that 16% of women and 8% of men had confirmed cirrhosis on biopsy, and that the women in this group reported shorter histories of excessive drinking than did the men (13 years versus 20 years).[11] The risk of developing cirrhosis also appears to increase at much lower daily doses of alcohol for women.[8]

In addition to their increased vulnerability to premature death from the same causes as affect male drinkers, women have special concerns about the impact of alcohol on reproduction. Pregnant women who drink heavily may cause damage to the foetus which is exposed to their excessive alcohol intake. With heavy alcohol use this may produce the Foetal Alcohol Syndrome (FAS) which is characterised by growth retardation, facial abnormalities, problems with the central nervous system and related problems. The effects of alcohol on foetal development are dose related and are not equal for all women. Approximately ten percent of the infants born to women who drink heavily may have FAS and another 20% to 30% may have a partial expression of the syndrome that is too subtle to measure.[12]

While abstinence from alcohol during pregnancy is clearly preferable, there is no convincing evidence that *occasional, light* drinking during pregnancy is harmful to the foetus. Recently, in the United States *any* alcohol use in pregnancy has been

used to stigmatise the mother. In some cases, any drug use has been viewed as supplying illegal substances to the foetus via the umbilical cord or breast milk, and hence a form of child abuse, the penalty for which is imprisonment of the mother for the duration of the pregnancy or lactation.[13] An unintended consequence of this policy is that pregnant women who have alcohol or other drug related problems may be less likely to seek medical attention during the course of their pregnancy, with grave health consequences to the mother, foetus and the community.[14]

1.1.3 Sex Differences in Alcohol and Drug Dependence

A variety of evidence suggests that men and women differ in the ways in which they become dependent upon alcohol and other drugs. The notion of dependence is a complex and problematic one. For the purposes of this monograph the features of alcohol and opiate dependence as described by Edwards and colleagues will be adopted. The central features of dependence are said to include a narrowing of alcohol and drug using repertoires, an increasing salience of substance use, tolerance to the effects of alcohol and other drugs and the experience of withdrawal symptoms upon cessation of use.[15,16]

A number of studies indicate that alcohol dependent women start both social and heavy drinking at a later age than alcohol dependent men.[17] In addition, women drink smaller amounts, and less often, for comparable levels of alcohol dependence. These data indicate a "telescoping" in the development of alcohol dependence in women, with a more rapid development of alcohol dependence problems in women than men.

The difference in the time course of developing dependence may reflect differences between men and women in the importance of genetic and environmental contributions to drug and alcohol dependence. Although the research in the past two decades has demonstrated a genetic contribution to alcohol dependence, this has primarily been conducted on male samples. Adoption studies in the 1970s provided stronger evidence of genetic influences for males than for females,[18] although these studies were limited by the small numbers of alcohol dependent women examined. More recent studies have also supported a stronger genetic contribution for males than females.[19]

Given the evidence of a stronger genetic contribution to the development of alcoholism for males, it may seem paradoxical that several studies have also reported that alcohol dependent women are more likely to report a family history

of alcohol problems than are alcohol dependent men.[20,21] In the United States National Drinking Practices Survey, for example, women with an alcohol problem were nearly twice as likely to have a father with an alcohol problem, and more than five times as likely to have a mother with an alcohol problem, than were men with alcohol problems.[22] There are several possible explanations of this finding. It may be that because of the greater social disapproval of heavy drinking among women, women who develop dependence are more likely to have a family history of alcohol problems, and are more likely to present for treatment. Alternatively, it may be that women are more strongly influenced by parental modelling of heavy drinking, or it may simply be that women are more willing to recall alcohol problems in the family than are men.

1.1.4 Sex Differences in the Correlates of Alcohol and Drug Dependence

The consequences of heavy drinking differ between men and women. While women accumulate the same number of alcohol related problems as men in treatment, they do so in four less years.[23] The types of problems alcohol and drug dependent women experience also differ. Women are more likely to experience family and psychological problems. This may be because the drinking of alcohol dependent women is more often solitary than that of alcohol dependent men, with women favouring private drinking either alone or with their partners at home rather than in public places where they may be vulnerable to physical attack and strong social disapproval.[24] Men more often drink in public places and with peers, and hence are more likely to experience conflicts with the public and legal sector as a result of their drunkenness. Because more men than women are in paid employment they have higher rates of job loss for inebriety than do women.[25] In addition, although alcohol dependent men display more violence when drinking than do women, it is women drinkers who are more likely to be the victims of violence.[26]

Concern about the medical consequences of alcohol use is one of the most frequently cited reasons why women seek treatment for their alcohol dependence.[27] Women dependent on other drugs also cite health problems as the primary reason for seeking treatment and drug-related physical problems as the reason for their first withdrawal.[28] It may be argued that the drug dependent lifestyle is frequently characterised by poor nutrition, inadequate hygiene and lack of attention to physical symptoms. In addition, the increased involvement in prostitution by women desperate for money, increases the probability of physical

disorders such as genito-urinary infection. Several investigators have reported that drug dependent women are at greater risk for cervical and uterine malignancies as well as other gynaecological problems, including a high level of dysmenorrhoea.[29] The same study reported that 42% of the women had dental problems and 38% had eye disorders. In a later study, the same author reported that the average drug dependent client in treatment had three health problems and that drug dependent women had more health problems on admission than did the men.[30]

Dependence on alcohol and/or other drugs is also associated with other debilitating disorders in women such as panic disorder and agoraphobia[31] and anorexia/bulimia.[32] While the nature of the relationship between these types of disorders and psychoactive drug use is uncertain, it appears that women presenting with these disorders should be carefully screened for concomitant alcohol or other drug problems because failure to treat disorders such as bulimia may precipitate a relapse to substance use[33].

In addition to health concerns, deepening depression is frequently cited as the main reason that many alcohol and drug dependent women seek treatment.[27] Alcohol dependent women are more likely to have attempted suicide than are alcohol dependent men [34] or non-alcohol dependent women. It has been estimated that between one-quarter and two-thirds of alcohol dependent people experience symptoms of depression that are severe enough to interfere with daily functioning.[35] Women are more likely to report such depressive symptoms than are men.[36]

For the majority of alcohol dependent people the symptoms of depression are caused by the effects of alcohol use and withdrawal on the central nervous system, and occur only during, or shortly after, periods of heavy drinking.[37] However, some symptoms of depression seem to be unrelated to consumption or withdrawal, and major depression that precedes alcohol dependence (primary depression) appears to cause more impairment than depression that occurs simultaneously with, or after alcohol problems.[38] It has been reported that the structure of depression in alcoholic and non-alcoholic women does not differ significantly.[39] Women generally appear to be more prone to suffer from primary depression than do men. However, alcohol dependent women with primary depression that is detected and treated are more likely to have an improved outcome than is the case for alcohol dependent men with primary depression.[38]

The self-esteem of alcohol dependent women has also been reported to be significantly lower than that of alcohol dependent men and non-alcohol dependent women.[40] In the same study it was found that the more alienated, socially isolated, depressed and anxious the alcohol dependent women felt, the lower was their self-esteem. The nature of the relationship between alcohol and other drug dependence and self-esteem is yet to be established. It may be that there is a causal relationship between self-esteem and alcohol dependence that operates in both directions: women with low self-esteem are more likely to misuse alcohol, and the misuse of alcohol, with its dysphoric effects and the increased guilt and social stigma, further decreases self-esteem. The effect of low self-esteem on the learning of new behaviours (such as abstinence or moderated drinking) is unknown, but it may be surmised that persons with low self-esteem believe that they are unable to learn new skills or feel insufficiently at ease with themselves to be able to enjoy life without the altered perceptions induced by high levels of alcohol or other drug use.

Women who are alcohol and drug dependent are more likely to engage in poly-drug use than are men.[41] Alcohol dependent women, especially younger women, are more likely to have a problem with tranquillisers, hypnotics, analgesics and/or amphetamines but are less likely to use other illicit drugs than are alcohol dependent men.[42]

1.2 Are Women Under-Represented in Drug and Alcohol Treatment?

The extent to which women with significant alcohol or other drug problems are under-represented in the treatment population is unclear. The Epidemiologic Catchment Area Study in the United States (ECA)[43] demonstrates that both men and women are under-represented in treatment in comparison to their numbers in the population. While it would seem reasonable to expect that women would be further under-represented in treatment in comparison to men, given the male bias of traditional mixed-sex treatment services and their lack of attention to the special treatment needs of women, such as child care and sexual issues, there is no compelling evidence that this is so from the data sets that are available in the United States and Australia.

Ideally, we would discover if women were under-represented in treatment by comparing the ratio of women and men with alcohol and drug problems in the community with the ratio of men and women in treatment. This would require data on the prevalence of drug and alcohol problems in the general population

using the same diagnostic criteria as were used in clinical practice. The ECA Study comes closest to providing the necessary information. This study involved a survey of the prevalence of psychiatric disorders in a sample of 20,000 persons from the general population in five sites. The presence of forty psychiatric disorders was diagnosed from interviews using the diagnostic criteria of the Third Revision of the American Psychiatric Association's Diagnostic and Statistical Manual.

The ECA Study provides some of the best information on the sex differences in the prevalence of alcohol and drug abuse and dependence. It confirmed that white males are 5.8 times more likely to receive a diagnosis of alcohol dependence than are white women. The size of the male excess has decreased in recent age cohorts from 6.5 among those aged 60 years or more to 4.1 among those aged 18 to 29 years. There was a smaller male excess among persons who received a diagnosis of drug abuse or dependence. Depending upon age, males were 1.2 to 4.1 times more likely to receive such a diagnosis, with an overall excess of 1.4.

The ECA Study also collected detailed data on the use of general and mental health services for specific psychiatric disorders. Unfortunately, most of these data remain unpublished. The only available data are those on sex differences in the proportion of persons with diagnoses of alcohol and drug abuse and/or dependence who have ever mentioned their problem alcohol or drug use to a health professional. These data do not show any under-representation of women. Indeed, by this measure, women with alcohol problems are over-represented in treatment (M:F ratio of 0.64), and women with drug problems are represented in approximately the same ratio in treatment (1.6) as their prevalence in the general population (1.4). These data are inconclusive, however, because they do not distinguish between primary medical care, mental health services and specialist drug and alcohol services. Women are more likely to seek medical care than men, particularly among the younger age groups. It is, therefore, likely that an under-representation of women in specialist drug and alcohol treatment has been masked by their over-representation among persons seeking other forms of health care.

The American National Drug and Alcoholism Treatment Unit Survey (NDATUS) of 1989[44] suggests that the ECA data over-estimated women's representation in drug and alcohol treatment. It was based on a one-week survey of patients receiving treatment for an alcohol or drug problem in any public or private service. These data indicated that the ratio of men to women in

alcoholism treatment was 2.94 (3.61 for in-patient and 2.86 for out-patient services), and that the ratio was 1.92 among persons in treatment for drug abuse (2.91 for in-patient and 1.79 for out-patient services). A comparison of these ratios with those reported in the ECA Study suggests that women may be over-represented in alcohol treatment, and marginally under-represented in drug treatment.

There are no Australian data on the prevalence of alcohol and drug dependence that are comparable to the ECA data. Instead, the nearest we have to population data is that on the prevalence of "high risk" levels of alcohol consumption derived from self-reported alcohol consumption among men and women in the community. Data on men and women in treatment is limited. It consists of data derived from a one-day Census of Treatment Agencies[45] and data on episodes of hospitalisation and bed days attributable to diagnoses of alcohol and drug dependence.[46]

Estimates of the ratio of men to women with high risk alcohol consumption and in treatment are provided in Table 1.1. The estimates of alcohol consumption have been derived in different ways in the two studies (by typical quantity frequency in the 1989 National Heart Foundation Risk Factor Prevalence Study,[47] and by last week of consumption in the 1989-1990 National Health Survey[48]). High risk in each case was broadly defined in accordance with National Health and Medical Research Council guidelines.[3] Although there are some discrepancies (the 45 to 64 year age group where the ratio is 1.6), both surveys indicate that men are 3.2 to 3.7 times more likely than women to consume alcohol at high risk.

The third column of the table provides the ratio of men to women in treatment for alcohol problems as derived from the 1990 National Census of Treatment Agencies.[44] This shows a consistent 3.5 to 5.1 times (4.0 overall) ratio of males to females in treatment. The sex ratios derived from the census data broadly agree with those derived from Holman and colleagues'[46] estimates of the morbidity attributable to alcohol dependence: the ratio of men to women was 3.9 for hospital episodes attributed to alcohol dependence, and 4.3 in the case of bed days attributed to alcohol dependence.

If we assume that males and females who drink at high risk are equally likely to develop dependence, then women are very marginally under-represented in treatment (0.8 to 0.9 times that of men). This may not be a reasonable assumption, however. The ECA Study suggested that heavy drinking men were 1.5 times more likely to become dependent on alcohol than heavy-drinking women. If the

Table 1.1

Ratios of males to females of high risk alcohol consumption in the National Heart Foundation Risk Factor Prevalence Study (1989) and the National Health Survey (1989-1990), and of treatment for a primary alcohol problem in the National Census of Treatment Agencies (1991).

Age Group	NHS	NHF	Census
18-24*	3.0	2.3	3.5
25-34	4.3	2.6	3.7
35-44	5.0	4.3	3.9
45-64	4.1	1.6	5.1
65-74 +	3.0	2.9	4.7
Persons	3.7	3.2	4.0

* 20-24 in the NHF + 65-69 in NHF 65 plus in the Census

ratios are adjusted to reflect this possibility, then the marginal under-representation of women in treatment disappears, and in fact women would be marginally over-represented in treatment (by 1.2 to 1.4 times). We hesitate to draw any strong conclusions from these data, which were not gathered for the purpose of discovering whether or not women are under-represented in drug and alcohol treatment. These data do indicate, nonetheless, that it would be premature to assert that women are under-represented in drug and alcohol treatment in Australia.

Data on the representation of men and women in treatment for illicit drug dependence is even more limited. In the case of illicit drugs our data sources are meagre. They consist of crude estimates of the population prevalence of ever

having used specific types of illicit drugs against which we can compare the Census data and data on hospital utilisation. The prevalence of ever having used illicit drugs such as heroin and cocaine is low in the general population, typically of the order of 1% to 3%, which is at the limits of the sample sizes used in the Australian National Campaign Against Drug Abuse surveys[49] to provide reliable estimates. As a consequence, the estimates of the ratio of male to female illicit drug users of 2.0 is imprecise. For example, in the 1985 survey with a total sample size of 2796 and rates of ever having tried heroin of 2% for males and 1% for females, the 95% confidence interval around the 2.0 ratio of men to women ranges from near equality (1.1), to a 3.9 times higher rate among men than women.

Comparison of the ratio of males to females among those who have ever used heroin with the ratios of men and women who have sought treatment for a primary opiate problem indicates that women may be over-represented in treatment for opiate dependence. For example, the ratio of men to women with a primary opiate problem in the Census of Treatment Agencies is 1.5, while the ratios in hospital episodes and bed days are 0.9 and 1.7 respectively. If it is assumed that men and women who have ever tried heroin are equally liable to become dependent, as seems to be the case in the ECA data[50], then these ratios suggest that women are over-represented in treatment.

For all their limitations, the Australian data do not provide strong support for the claim that women are under-represented in treatment for alcohol dependence. In the case of illicit drug use, and particularly heroin, the picture is less clear. There is a tentative suggestion of an over-representation of women in treatment for opiate dependence. The differences found in rates of treatment attendance between women with alcohol and opiate related problems may be because of the differential contact rates with the social welfare and criminal justice systems due to the illegal nature of their substance use. The criminal justice system may be more likely to direct women using opiates into treatment and opiate dependent males to a custodial sentence. Opiate dependent women are also much more likely to come to the attention of the legal and welfare systems than are alcohol dependent women due to the illegal nature of their substance and because they are likely to be directed onto a methadone program when they become pregnant. In the case of dependence on other illicit drugs and prescription drugs there is insufficient Australian data to confidently say whether women are under- or over-represented in treatment.

1.3 Special Issues for Drug and Alcohol Dependent Women

While there have been few empirical studies on the special treatment needs of drug and alcohol dependent women, certain issues can be readily identified that are not adequately dealt with in traditional mixed-sex services. The extent to which such programs fail to address these issues may provide barriers to treatment entry for drug and alcohol dependent women. The analysis which follows is based upon a wealth of clinical anecdotes, descriptions of women in treatment, comparisons between women and men in treatment and theoretical analyses of the special treatment needs of drug and alcohol dependent women.

1.3.1 Stigma

When the rôle of women in society is equated with the stabilising functions of wife and mother, drunken women pose a special threat. While drunken behaviour by either sex is socially condemned, a drunken woman is doubly so. A number of researchers[51,52] have reported that women with substance use problems believe that society in general views them as more 'out of control' and morally degenerate than men with similar problems. In a recent Irish study, for example, 86% of women in treatment for alcohol problems believed that women with drinking problems are more likely to be rejected than men. As a consequence, more than half of these women were still hiding their drinking when they entered treatment.[53]

One result of this greater social stigma attached to women with substance use problems is that they may be more reluctant to enter a treatment facility for drug and alcohol problems, where their diagnosis will be obvious. They may be even less likely to seek treatment in an agency that uses confrontational techniques, wherein women are forced to accept and identify with the stigmatising label of "addict" or "alcoholic". It is not surprising that women with substance use problems are more likely than are men[54] to seek medical treatment for interpersonal or psychological problems, or to contact psychiatric services[55] without informing these professionals about their alcohol or other drug problems.[56]

1.3.2 Childcare

The majority of women with substance dependence problems are mothers.[57] Concern about losing custody of their children often prevents these women from admitting that they have a problem with alcohol or other drugs. A significant

proportion of women not only have concerns about government agencies removing their children, but are also unable to afford, or do not have access to, appropriate childcare while they seek treatment. The positive effect of providing childcare on the ability of a service to attract and retain women with dependent children has been shown in demonstration projects in the United States.[58,59]

The parenting concerns of women with drug and alcohol problems are rarely addressed in traditional mixed-sex treatment settings. In one study, only 15% of the women reported that they were able to use the drug abuse treatment program as a place in which to discuss child rearing problems.[60] The magnification of existing feelings of guilt, shame and failure surrounding their maternal rôle, if left unaddressed, may negatively affect treatment outcome as women use alcohol or other drugs to cope with these intense emotions after discharge.[61] The failure to address these issues may also leave a legacy of unsatisfactory child-rearing, malnutrition, developmental delays, learning disorders, and an increased risk of substance abuse among the children of substance dependent women.[62] Therefore, attracting women with dependent children into treatment may also reduce the risk of problems in the next generation developing alcohol and other drug related problems.

1.3.3 Sexual Preference

The incidence of substance dependence problems is frequently reported to be higher among lesbian than heterosexual women.[63,64] Lesbian identity is not limited to sexual activity but encompasses a primary ontological orientation toward women, a lifestyle preference that is "women centred", and "a way of being" that is women relating.[65] In the United States, approximately 10% of the general population are alcohol dependent compared to estimates of around 30% of the lesbian population.[66] This increased lifetime prevalence of heavy and problem drinking was not explained by personality traits, psychiatric diagnosis, gender identity, history of frequenting gay bars or family history of alcoholism in one of the few studies conducted in this area.[67] However, the studies that are available are limited by small sample size, lack of controls, non-random samples and inconsistent definitions of homosexuality.[68] The concerns lesbian women may have about homophobia, male sexual harassment and lack of understanding by staff and clients of their treatment needs mitigate against their entering, remaining in, and benefiting from, traditional mixed-sex alcohol and other drug treatment services.[69] These special treatment needs may include a desire for a female-only

environment, an understanding of their social world, and an ability to understand their differing cues to relapse.

1.3.4 Sexual Harassment and Sex Rôle Stereotyping

According to feminist theorists, sex rôle stereotyping and sexual harassment are symbiotic: when women display sexually stereotyped behaviours they are more vulnerable to sexual harassment, and when superior social and physical power is used to sexually exploit women, they are forced into stereotyped passivity and a dependent attitude towards males.[70] There is a paucity of empirical evidence on these issues in alcohol and other drug treatment; the only supporting evidence is based on clinical lore and anecdote. Studies have shown that in traditional mixed-sex drug and alcohol treatment programs female clients were encouraged to pursue interpersonal relationships rather than their educational and vocational needs.[71] It is interesting to note that one study found that whereas female staff members believed that all residents should do the same chores, male staff were divided on the issue. An analysis of the jobs to which residents had been allocated revealed that residents did not get the same assignments, and hence that the wishes of female staff had not prevailed.[72] It appears from this evidence that traditional treatment services reinforce the socialisation of women into dependency. While dependency on people or substances for a woman is socially unacceptable when it interferes with her rôle as a housewife, mother or worker, it is seen as positive when it involves being dependent on a man, male protection or male professionals.[73]

It is not only male staff who may engage in sexual stereotyping and harassment; male treatment clients may also be involved. The illicit drug scene is male dominated, with men frequently doing the majority of drug "scoring". There is also often a strict rule that men go first in drug and equipment use, a practice which leaves women open to increased risk of contracting infections such as HIV and hepatitis A,B and C. In a mixed-sex treatment group, where the masculine model of competence prevails, the women who demonstrate dependent, submissive and receptive behaviours will be reinforced.

It also appears that drug and alcohol dependent women slip easily into pleasing rôles, patterns of manipulation, acceding to male authority and exhibiting hostility towards other women in a mixed-sex group.[74] Male clients may act out their feelings of powerlessness in the treatment setting by sexually harassing female clients. Male staff members may also use the power differential to sexually

and/or emotionally exploit vulnerable and needy women clients, especially if they have graduated from the program themselves and received little or no training in counselling.[75] On the other hand, women who have rejected traditional role models may be reluctant to discuss their experiences with a male therapist or in a group with men. In this way women in a mixed-sex treatment setting with a male therapist will not be provided with a rôle model of assertiveness and competence.

1.3.5 Sexual Abuse

Women who have a history of sexual abuse in childhood and adult life appear to be over-represented among women seeking treatment for alcohol and drug dependence[76] and psychiatric disorders.[77] This may reflect the long-term consequences of unresolved sexual abuse, particularly in childhood, but it is difficult to be sure because the literature on the rôle of sexual abuse in the aetiology of substance dependence lacks clarity and consistency of definition, and there are few controlled studies that have used prospective designs. The sequelae of childhood sexual abuse has been likened to the symptoms of the post-traumatic stress syndrome, which include chronic fear, reliving the experience in a variety of ways, and feelings of anxiety, anger and depression.[78] In accord with relapse prevention theory,[79] it has been suggested that an alcohol or drug dependent woman who has not had the opportunity to resolve these symptoms is more prone to relapse because she lacks the skills necessary to deal with flashbacks or nightmares.[80]

Women who have been sexually abused in childhood appear to have a strong need for a physically and emotionally safe treatment environment because their trust has been seriously violated in the past.[81] Such women feel especially vulnerable in a residential mixed-sex treatment environment. In addition to lack of physical safety, these women are unlikely to discuss these experiences in a mixed-sex group, or with male therapists. Therefore, traditional mixed-sex treatment services are unlikely to appeal to women with a history of sexual assault.

1.3.6 The Rationale for Specialist Womens Treatment Services

The creation of specialist womens treatment services has been one suggested way for dealing with the insensitivity of existing drug and alcohol services to the special issues of women. Such services would provide treatment by women, for women. They aim to address the special issues facing drug and alcohol

dependent women, such as sexual issues and sexual abuse, in a safe and secure environment that provides care for dependent children. The existence of such services also enables women practitioners to develop the necessary expertise to deal with drug and alcohol dependence in women, expertise that could be used to better meet the needs of women within traditional mixed-sex services.

The development and empirical validation of such specialist treatment services for women has been frustrated by the paucity of research in this specialist area. Despite the growing theoretical support for the provision of such specialist services, little empirical work has been conducted on them because so few services have been established, and even fewer have been extensively researched. As a consequence, the bulk of the published literature on these services consists of service descriptions[83-85] and a small number of uncontrolled treatment outcome studies that lack comparison groups.[86,87] The effect on treatment outcome of moving away from the prevailing male-dominated models of treatment for women has yet to be adequately tested.

The sole exception is a study conducted by Dahlgren and Willander in Sweden.[88] This was a 2-year follow-up study of women who were attracted into treatment at an early stage of alcohol dependence. The median age of the women was 42 years, 90% were employed, and two-thirds lived with a male partner. None of the women had received previous treatment, had a history of psychosis or used narcotic drugs. The women were randomly assigned to be treated in either a specialist womens' unit or in a traditional mixed-sex treatment service. The specialist treatment consisted of a medicated detoxification and a brief in-patient hospitalisation in a unit that employed only professional staff (physicians, nurses, psychologists and social workers). The residential treatment phase was followed by a one-year out-patient program that consisted of individually tailored programs. It included thorough medical care and psychological, social and welfare investigations, and was delivered in individual and group sessions.

At two year follow-up, the women who attended the specialist womens service had a more successful outcome in terms of alcohol consumption and social adjustment than the women who attended the traditional mixed-sex service for a comparable length of time. This important study requires replication in a variety of settings with samples of women with varying degrees of substance dependence on a variety of drugs. The present study attempted to replicate this study. It took advantage of the recent introduction of a specialist womens treatment service to evaluate its impact on drug and alcohol use in a population of women who were

more severely dependent on drugs and alcohol than those treated in the Dalhgren and Willander study.

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CHAPTER 2 Design of the Evaluation

2.0 Introduction

A condition of initial and continued funding was that Jarrah House would be evaluated. The first evaluation was in the form of an observational report commissioned by the Drug and Alcohol Directorate, New South Wales Department of Health. Ms. Leslie Dawes spent up to ten hours per week for ten weeks between July and September 1987 at Jarrah House, speaking to clients, staff and members of the management committee. She concluded that: (1) the stated aims and objectives of the program were not being realised; (2) the disease model of addiction was the sole basis of treatment with no alternative model being offered; (3) there was insufficient continuity of care post-discharge; and (4) there was lack of involvement of the clients' "significant others" in the program.

In 1988 funding was granted from the Commonwealth Government National Campaign Against Drug Abuse (now the National Drug Strategy) to conduct a prospective outcome evaluation of the Jarrah House Program. The project was jointly supervised by the Directorate of the Drug Offensive (now the Drug and Alcohol Directorate) of the New South Wales Department of Health and the National Drug and Alcohol Research Centre. The project officer (JC) was employed in April 1989 and began by finalising the methodology and instruments to be employed for the study. Ethics Committee approval was sought from each of the institutions and the project explained to the staff at each of the centres.

The central questions to be addressed in the evaluation were as follows:

1. Does a specialist women's service attract a different group of women into treatment than traditional mixed-sex services? More specifically, do specialist women's services attract women into treatment earlier? Do they attract more women with dependent children, more lesbian women and more women with a history of sexual abuse in childhood and adulthood, than do traditional mixed-sex services?

2. Does a specialist women's service retain more women in treatment so that they stand more chance of benefiting from the experience? More specifically, do such services reduce treatment drop-out, particularly among women with dependent children, lesbian women and women with a history of sexual abuse in childhood?

3. Does a specialist women's service produce greater client satisfaction with treatment because they meet more of the special needs of drug and alcohol dependent women?

4. Does a specialist women's service improve treatment outcome? That is, are specialist womens services more effective in reducing substance use, unemployment, and criminal activity, and in improving womens health, depression, degree of social support and level of maternal satisfaction?

2.1 Evaluation Design

All of these questions presuppose a comparison of the performance of specialist treatment with that of traditional mixed-sex services. The first question can be addressed by describing the characteristics of the women attracted to the two types of services. Ideally, the remaining questions would be best addressed by a randomised control trial of the type conducted by Dahlgren and Willander.[1] In such a study women with drug and alcohol problems would be randomly assigned to be treated in either a traditional mixed-sex service or the specialist women's service. The two treatment groups would then be compared in terms of treatment retention, client satisfaction and treatment outcome at six and twelve months post-treatment. The randomisation of women to treatment program would ensure that the two groups of women had problems of equivalent severity, thereby enabling the effects of the programs to be distinguished from the characteristics of the women attending the two types of program.

In the present case a randomised controlled trial was not a practicable option as the research team had no control over the allocation of subjects to treatment; moreover, it is doubtful that this would have been acceptable to the staff in the programs that were evaluated. Consequently, the study design was a comparative outcome study which involved a six month study of changes in drug and alcohol use and associated problems in women attending Jarrah House and in a comparison group of women attending two traditional mixed-sex treatment agencies. It was necessary to use two comparison centres because of the low numbers of women presenting to mixed-sex services.

The inability to utilise a randomised design meant that the equivalence of the two groups of women could not be assumed and, indeed, was unlikely in the event that the specialist womens service aimed to attract a different clientele from that of the traditional mixed-sex services.

A quasi-experimental strategy was adopted to deal with the possibility of differences between the characteristics of women in the specialist and mixed-sex services.[2] This was carried out in two stages. The first was the measurement of the relevant characteristics of women in the two programs that would be expected to affect treatment outcome. The second was the use of statistical methods to discover whether any differences in outcome, or failures to find such differences, were explained by differences between the characteristics of the women who entered each type of program.

A further difficulty with this design was that the researchers had no control over the treatment process. As a result, it only became clear in the course of the process and impact aspects of the evaluation that the therapeutic model employed was not the "demonstration model" of an empathic and empowering feminist service intended by the women who established it.

2.2 *Selection of the Comparison Programs*

The two mixed-sex services chosen were Wisteria House at Cumberland Psychiatric Hospital and what was then known as Ward 4 at Mosman Hospital. These services differed from each other and from Jarrah House in their length of stay but this was unavoidable. They were nominated as they had the least population overlap with client population of Jarrah House, and together they were estimated to treat approximately equivalent numbers of women to Jarrah House. The plan was to recruit eighty women from Jarrah House and eighty women who had attended either of the two mixed-sex services. These sample sizes were ones that could be realistically achieved over the period of a year in which women would be recruited into the study, a choice of time which meant that the evaluation study would need to be conducted over two years. A larger sample size would have been desirable from the point of view of statistical power for comparisons of the two programs (see section 2.5.2) but it was not possible because of restrictions imposed by the number of beds in each program, the average lengths of stay, and the budget of the evaluation study.

2.3 *Subject Selection*

Women recruited into the study were those who were admitted to one of the three programs between August 1989 and October 1990. Women were excluded from the study if they had been admitted to any of the other services in the study, or if they had obvious, serious cognitive impairment. In the sample studied, it was not

feasible to exclude women with no fixed abode as they made up a large proportion of the population. The researcher (JC) approached all the female clients at each treatment agency, who were physically and emotionally well enough to take part in the study, and explained the nature of the project. Eight women approached at Jarrah House and four who were approached at Wisteria House and Mosman Hospital refused to participate in the study. In the majority of cases, refusal to participate indicated that the client planned to discharge herself from the agency. The consent form emphasised the voluntary nature of participation and sought their agreement to be contacted six months after discharge for re-interview.

2.4 Measures

A comprehensive standardised interview was used to obtain the necessary information to answer each of the study questions. Interviews were conducted shortly after admission, immediately prior to discharge, and at six months post-treatment.

2.4.1 On Admission

The first interview was conducted on an average of six days after admission to allow time for detoxification, and to exclude women who left the service within forty eight hours. Data were gathered using a structured interview (Appendix A). The admission interview collected a great deal of information on demographic characteristics, life history, drug and alcohol history and psychosocial adjustment, all of which was relevant to answering the first question, namely, whether the specialist womens service and the two traditional mixed-sex services attracted different women into treatment.

The demographic characteristics included age, marital status, living arrangements, number of dependent children and ethnicity. The information on life history included the woman's obstetric history, whether she had experienced any legal problems, the level of education she had achieved, her employment history, whether there was any family history of drug or alcohol problems, her general health status, her sexual orientation, whether she had worked as a prostitute, and whether she had a history of sexual and physical abuse in childhood or adulthood.

The information about the woman's drug and alcohol history included the age at which drug use was initiated, and any past treatment history for drug and

alcohol problems. The woman's current pattern of drug use was assessed by the Opiate Treatment Index - Drug Use Scale.[3] Her degree of drug dependence was assessed by the Severity of Alcohol Dependence Questionnaire (SADQ)[4] in the case of women whose preferred drug was alcohol, and the Severity of Opiate Dependent Questionnaire (SODQ)[5] in the case of women whose preferred drugs were opiates.

The information on psycho-social adjustment included the following: the degree of family support provided to the woman for seeking treatment on this occasion; the mode of referral to the service; the degree of depression as assessed by the Beck Depression Inventory (Short Form),[6] a self-report inventory of depressive symptoms; the woman's level of self-esteem as measured by the Coopersmith Self-Esteem Inventory [7]; their level of social support as assessed by a Social Support Inventory; and for women with dependent children, their degree of satisfaction with their child-rearing skills as assessed by a Maternal/Child Relationship Index. The latter two scales were developed specifically for the study as no satisfactory scales were available. The details of their psychometric properties are reported in Appendix B and C respectively.

All of this information enabled the following specific questions to be answered:

1. Did the specialist service attract a demographically different clientele than the mixed-sex services?

2. Did the clientele of the specialist service include more women with dependent children, more lesbian women, more women with a history of sexual and physical abuse, and more women with more severe drug and alcohol problems?

2.4.2 Drop-Out Study

During the initial stages of the project, it became apparent that there was a substantial rate of drop-out early in treatment. This became the subject of a small study. In addition to assessing the rates of treatment drop-out for the two types of treatment service the characteristics of women who dropped-out of treatment were examined to ascertain whether a specialist women's service had any impact on this process. As a result, the one hundred and sixty women already enrolled in the study who had stayed more than five days in treatment were compared

with one hundred and sixty women who left treatment against advice less than five days after admission for drug and alcohol problems.

Data collection for women who stayed less than five days in treatment were obtained from the agency's client records. Where the agency's routine admission assessment instruments were not adequate, the researcher provided an additional questionnaire to be completed by all female admissions.

The information gathered included age, marital status, sexual orientation, dependent children, loss of custody of children, child-care arrangements during admission (if necessary), occupation, current employment status, main source of income and ethnicity. Questions explored her life history of having worked in the sex industry and whether she had ever experienced sexual and/or physical abuse. Her drug and treatment history was examined including her mode of referral, reason for presentation, drug of choice, length of problem use, number of previous treatments, attendance at Alcoholics/Narcotics Anonymous, number of previous methadone maintenance programs, the reason for discharge and her plans after discharge from the current admission.

2.4.3 *At Discharge*

For those women who remained longer than 48 hours, the second interview was conducted by JC on an average of two days prior to the subject leaving the treatment service. This interview was completed with 82% of subjects overall, which comprised 74% of women from Jarrah House, and 90% of women from Wisteria House and Mosman Hospital.

The structured interview covered a number of areas that were relevant to the comparison of the clients' experience of treatment in the specialist womens and traditional mixed-sex services. These included their satisfaction with the treatment they had received, measures of their symptomatic improvement on depression and self-esteem during treatment, and their confidence in their ability to control their drug use in a variety of situations that they were likely to experience after their discharge.

The information on their treatment experience included: the length of stay in the program, whether they had undergone a medicated or non-medicated detoxification; the sex of their primary therapist during their stay; their reason for leaving at that time; their ratings of the usefulness of various components of the treatment they had received; and their satisfaction with their treatment as assessed by the Attkisson Client Satisfaction Questionnaire.[8] The womens psycho-social

status at discharge was assessed by their degree of improvement on the Beck Depression Inventory (SF), and the extent of increase in self-esteem as measured by the Coopersmith Self-Esteem Inventory. Their degree of confidence in their ability to deal with various situations relevant to drug use was assessed by Annis' Situational Confidence Questionnaire (SCQ-39)[9] for subjects who primarily had alcohol problems, and by Annis and Martin's Drug-Taking Confidence Questionnaire[10] for all other subjects.

2.4.4 *At Six Months Follow-Up*

The follow-up interview was conducted on an average of 27 weeks after discharge (range 24-32 weeks). The follow-up rate was 61%, with 65% of women from Jarrah House and 56% of the women from Wisteria House and Mosman Hospital (Comparison Services) being interviewed. Five percent of the Comparison Services and 2.5% of the Jarrah House sample refused to be interviewed at follow-up.

The follow-up interview was conducted by a research assistant (VB) who was unaware of the type of treatment service the subject attended. Although the vast majority of interviews were conducted in person, telephone interviews and mailed-out versions of the questionnaire were used where time or distance was a problem.

This structured interview explored life events and circumstances, drug and alcohol use and treatment history, and psychosocial adjustment in the period since the episode of treatment that led to the woman's inclusion in the study. The Intervening life events were assessed by the Schedule of Life Events,[11] the woman's living arrangements, and her obstetric history, legal problems, employment record and general health since treatment. The intervening drug and alcohol history was assessed by drug use in the previous month by the Opiate Treatment Index - Drug Use Scale, any episodes of treatment since discharge, the woman's experience of on-going treatment, and the woman's retrospective view of the extent to which her treatment had been useful. Psychosocial adjustment at the time of the six month follow-up was assessed by the Beck Depression Inventory (SF), Coopersmith Self-Esteem Inventory, the Maternal Satisfaction Scale, the Social Support Inventory, and Annis' Situational Confidence Questionnaire (SCQ-39) for subjects with primarily alcohol problems, and Annis and Martin's Drug-Taking Confidence Questionnaire for all other subjects.

2.4.5 *Collateral Data Collection*

Subjects were asked to nominate someone that they lived with or saw more than three times a week to provide collateral data on their drug use, treatment history and psychosocial adjustment. Collateral information was provided by 74% (79% from Jarrah House, 69% from Comparison Services) of the subjects who were successfully followed-up. The most commonly stated reason for not supplying a collateral was that in the woman's view these people were unlikely to be aware of the extent of their drug use and related problems. The collateral interview was conducted by telephone and the following information was recorded: the collateral's relationship to the client, when the client was last seen, how many times per week the client was seen; the collateral's estimates of the client's drug use, number of house moves, employment, drug use by significant others, level of criminal activity, any unexplained absences of more than a day, health, and presence of major life events. (See Appendix A for more details.)

2.5 *Data analysis*[a]

2.5.1 *Reporting of Results*

The results of the study are reported in such a way as to make them readily understandable. The term significant should be read as "statistically significant" and the reader will be directed to appendices where an account of the statistical procedures used may be found. In addition a great deal of the material has been published in peer reviewed journals and the reader may wish to refer to these for statistical queries.[12-14]

2.5.2 *Statistical Power*

Because of the restrictions of the sample size, the study only had adequate statistical power to detect a "medium" sized, or larger, difference between the Jarrah House and Comparison Services in terms of conventions for describing effect sizes.[15] This means that failure to find a statistically significant difference does not exclude the possibility that a small to medium sized effect has gone undetected.

The low statistical power had two consequences for the statistical analyses and their interpretations. First, no adjustments were made for the number of tests

[a] *See Appendix B for details of statistical procedures*

conducted to avoid further reduction of the already low statistical power. Second, to minimise the tendency of interpreting "non-significant" results as meaning "no difference" we have reported the 95% confidence intervals around all measures of difference (either mean differences or odds ratios) where the upper limit of the 95% confidence interval indicates the largest difference in the population that is consistent with the sample result.[16]

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CHAPTER 3 Jarrah House: Development of a Treatment Service

3.0 Introduction

The following is a brief description of the history of Jarrah House, based on interviews with a number of key players, and a reading of available policy documents, submissions and minutes of management committee meetings. It is impossible to represent every participant's perspective when reviewing a complex organisation and the authors apologise to those who feel their story has not been told. The importance of recording this history is that it conveys valuable lessons to others contemplating the establishment of a specialist or non-government service in the future.

3.1 Conception

In 1984 a group of women who were working as drug and alcohol clinicians, educators and researchers became increasingly conscious of the lack of appropriate services for alcohol or other drug dependent women in Australia. In response to this perceived need they organised the inaugural Women and Dependence Conference which was held in Sydney later that year. This conference was used to develop an awareness of the special treatment needs of women with substance dependence problems, and to develop strategies to meet those needs. Following this conference, a group of about 15 women met in an inner-city neighbourhood centre to discuss a proposal to establish a short-term, residential treatment service that provided residential childcare and an all female staff.

It quickly became apparent that such a large and diverse group represented a variety of philosophical positions, some of which were incompatible. The recording of these differences is important, as there have been recurring sources of conflict throughout the history of the project about the function of the management committee and the daily operation of the service. The first group of questions centred on the philosophy and organisational structure of the service and the second on the issues of treatment protocols and procedures. While all the members of the group supported the notion of women choosing the type of treatment for their alcohol and other drug problems, there was no consensus on what choices women would be offered. The most divisive issue to be addressed by this group was whether the service should be operated as a feminist collective or should use a professional hierarchical model of organisation. A number of the group who did not wish to be associated with a women's service that was not explicitly a separatist, feminist collective left the group at this stage. However, while the feminist collective model was not explicit at this stage of development, it

later became clear that a significant proportion of the women in the group still perceived the service in this way. It is important to clarify that since Jarrah House was always to be a feminist-oriented service aimed at "empowering" women in their life changes, the issue was purely one of managerial style and not of philosophical approach to the treatment of women with substance use related problems.

Related to this basic structural issue were disagreements about the most appropriate rôle of the management committee. These questions included: (1) to what structure should the management committee conform?; (2) how would decisions regarding the nature of the program be made?; (3) what level of involvement should the management committee have in the everyday operation of the service?; and (4) what procedures should be implemented for ensuring accountability, and to whom?

Another major issue to be resolved was whether or not the women should be offered the choice of a medicated detoxification. Many of the women in this group came from a background of traditional drug and alcohol service delivery that was abstinence oriented. Such services operate on the philosophy that although the health of the clients should not be endangered the women should experience the physical discomforts of withdrawal and not resort to medication as they have in the past to reduce their physical or emotional pain. This strongly held view is incompatible with a more flexible model of giving women the choice of how they deal with the physical aspects of their withdrawal (especially if their fear of withdrawal is what deters them from seeking treatment) as long as they are not medicated to the point of euphoria.

The discussions around these topics led to a loose consensus among a core group of about eight women who then went on to write the funding proposal and to steer the proposal through the complex process of translating a concept into reality.

3.2 *From a Proposal to a Treatment Service*

The women who remained formed a management committee called the Women's Alcohol and Drug Action Committee (WADAC). In 1985, this committee submitted a funding proposal to the Commonwealth Government National Campaign Against Drug Abuse (NCADA) which was based upon a review of the literature on the treatment needs of women. Because of the lack of empirical

research in the area, the review was founded on clinical lore, feminist theory and the clinical impressions of the committee members.

It was decided that the service should be named Jarrah House, which is derived from an Australian Aboriginal term meaning "tall and straight." While the service itself was to be apolitical, the women on the committee were sufficiently experienced to be aware that a concerted campaign to raise the awareness of politicians would be necessary. To this end, all politicians were provided with a copy of the funding submission for comment. An accompanying letter explicitly addressed their potential concerns that the service may operate on a separatist-feminist philosophy. It also emphasized the importance of the agency being located in the under-serviced western suburbs of Sydney, and supported the prevailing notion that detoxification services should be placed within existing public hospitals.

In 1986, the Commonwealth NCADA funding was approved for distribution through what was then known as the New South Wales Department of Health Drug and Alcohol Authority, a statutory body responsible for overseeing all non-government drug and alcohol services. One of the initial difficulties with the funding bodies was that the funding requirements were calculated on the number of women clients only, and it took the WADAC members some time to educate the relevant government departments that Jarrah House was also to provide a service for children who should be included in the client numbers.

In February 1986, negotiations commenced with the Canterbury District Hospital to locate Jarrah House across the road from the main hospital in the vacant resident medical officers quarters. These negotiations were complicated by the concerns of the hospital board over control of the operations of the service. These included anxieties of the medical staff that its presence would erode their clinical service and that they would have to "rescue" clients who had been medically mismanaged on a regular basis. Some examples of the board's objections may convey a clearer impression of the types of difficulties faced by this non-government, women's drug and alcohol treatment service.

The WADAC members were advised by the board to have a lease drawn up that was modelled on one that the hospital had drawn up with a local childcare centre. This lease was prepared as requested but was rejected by the board. Another lease prepared by the board's solicitor took three months to draft. The WADAC members were forced to reject this lease, which was for only three years, because they were concerned that as a large sum of public money was being used

to establish the service it was necessary to have security of tenure. The lease also included the following conditions: the service was only permitted to operate during traditional business hours, no musical instruments were to be played, strict dress codes for staff were to be applied, and a person nominated unilaterally by the board was to sit on the management committee. These conditions were rejected by WADAC as onerous and inappropriate and it required intervention by the State Minister for Health for the matter to be resolved.

The importance of intense political lobbying by the WADAC members in the successful opening of the service cannot be underestimated. The local member had made the opening of the service an election promise and the recommendation for it to be supported was explicit in a recent Federal Government review of women's health needs. Added to the issue of women's services was the increasing emphasis at that time for improved health care services, in general, in the growing areas of the western suburbs of Sydney.

Jarrah House was due to open on the 11th of May 1987; however, the difficulties with the lease arrangements with Canterbury District Hospital delayed the opening.

3.3 The Birth of Jarrah House

The premises leased from the hospital required renovating to a standard suitable for a residential treatment service. A member of the WADAC committee made herself available to supervise these renovations and the committee members were required to be on the premises out of business hours to supervise painters recruited from the Corrective Services Department.

3.3.1 Staff Recruitment

The management committee were anxious to ensure that the staff represented a wide variety of lifestyles and levels of experience. While applying equal opportunity employment principles, the committee was concerned that women who were single, married, heterosexual, lesbian, mothers, avowed feminists and from a variety of ethnic backgrounds, were represented among the staff. As it was a legal requirement that a registered nurse be rostered on each shift, nurses made up around two-thirds of the staff. The remaining positions were filled by women who were recovering from alcohol or other drug dependence, who were generally untrained. Apart from the initial recruitment, the only two positions

that were appointed as a result of the deliberations of a panel of interviewers, were those of co-ordinator and drug and alcohol counsellor.

3.3.2 The Early Days

Jarrah House opened on the 24th of July 1987. Despite the initial difficulties in the relationship with the board of Canterbury Hospital, the hospital subsequently provided food, linen and accounting services to Jarrah House.

During the first two weeks of its operation Jarrah House was run as a series of workshops in which the management committee presented their vision of a specialist women's service, and inculcated enthusiasm for this innovative agency to the staff. The first challenge to the successful operation of Jarrah House was the mix of staff backgrounds. While it was noble to attempt to represent the interests of all potential women clients, in reality a small service cannot sustain a variety of competing political and professional points of view. The personal experiences and political views of the staff, as well as their differing expectations for the service, were a frequent source of tension. While in time the majority of such disagreements have been resolved by movement of all to a "middle ground", the notions of choice and alternative approaches have yet to be definitively addressed.

3.3.3 We Don't All Share the Vision?

It came as an enormous shock to the management committee that they should be confronted by industrial problems within a month of opening Jarrah House. The committee made a point of offering a professional service and paying professional rates of pay to the registered nurses that they employed. Non-government organisations are sometimes forced to pay their (frequently female) staff a flat salary rate. Since the majority of the staff received these professional rates of remuneration, there was a discrepancy between their salary and that of the minority of non-professionally trained staff. This led to some resentment and a letter was written to the WADAC committee pointing out that they were "all workers together" and should receive the same payment. This concern prompted the management committee to draft contracts of employment for all the staff to sign, pointing out their terms and conditions of employment.

It became clear that the issue of whether or not Jarrah House was to be run as a collective had not been finally settled in the minds of both the committee and the staff. The initial organisation of the service was undertaken in a task-oriented

way, which disguised the lack of underlying cohesiveness of the committee. Three months after Jarrah House opened, the staff members wanted to vote out the management committee and run the service as a collective. The WADAC members had anticipated this action (as a result of their experiences in other non-government organisations) and had incorporated in December, 1986. The incorporation necessitated a change of name to the Women's Alcohol and Drug Advisory Centre. At this time the committee set itself up as an eight-member group with eight executive positions, thereby, closing the membership to that of "by invitation only". This action was taken to prevent the committee members being voted out of office by the staff members after they had put in a great deal of work to realise their vision for the service and to ensure that the service was operated in the way required by the funding bodies.

The committee at this time comprised Ms. Carol McCaskie (Director of Nursing, Langton Centre), Ms. Sandra Fleischman (Methadone Co-Ordinator, NSW Health Department), Ms. Liz Chaikin (Psychologist, Regional Drug and Alcohol Unit, Chatswood), Ms. Sue Blair (Registered Nurse, McKinnon Unit), Ms. Pauline Mathewson (Chartered Account, Coopers & Lybrand), Ms. Jane Mills (Project Officer, Drug and Alcohol Authority), Ms. Bethne Hart, Education and Training Officer, Centre for Education and Information on Drugs and Alcohol), and Ms. Colleen Sutherland (NSW Corrective Services). The act of bringing the issue of a collective management style to a head meant that a number of the committee members resigned and the clear decision that the service was to be organised along hierarchical lines was made by WADAC.

3.4 The Problems of Infancy

Having opened the service and having dealt with many of the initial difficulties, the WADAC members hoped to be able to hand over the daily operations of Jarrah House to the co-ordinator. The committee, however, was unsure about the most appropriate pre-requisites for the extremely challenging position of co-ordinator. Nor had the committee reached a consensus on either the most appropriate qualifications for staff members or the required balance of professional and ideological backgrounds. This lack of consensus was reflected in the decision to have two separate interview panels, with minimal communication between the two, to undertake the initial staff selection.

The first co-ordinator left the position after three months. She had worked for many years as a social/welfare worker in a large rehabilitation hospital. Her

comments on the experience at Jarrah House centred around the unresolved issue of whether or not the service was to be run as a collective. This meant that her authority as a manager was undermined and the lines of communication between the committee and the co-ordinator were unclear. The extraordinary mix of staff backgrounds also meant that there were frequent disputes. In addition to the problem of their disparate backgrounds, was the difficulty that the majority of the staff were employed on a part-time basis. This meant that it was extremely difficult for all the staff to meet to discuss issues. This constant fragmentation and lack of direction drained the energy of the co-ordinator.

Following the resignation of the first co-ordinator the management committee seconded one of their members to take up the rôle. This person was a former nursing unit manager of a public hospital detoxification service, and had the required clinical background in drug and alcohol treatment to also address some concerns that had been expressed by the visiting medical practitioners regarding aspects of clinical practice by less experienced staff members. The four months of this secondment was used to conduct inservice training and to attempt to inspire the staff with the management committee's vision of the way a women's service should function. While some basic protocols of detoxification and job descriptions were formulated at this time, even today there is no protocol describing the ways in which the stated aims and objectives of the service are to be put into operation.

When recruiting for the third co-ordinator, the WADAC committee hoped to employ a registered nurse but no suitable applications were received. The person appointed had a background in social welfare and had worked for Corrective Services. This person provided a period of stability to the service. While this time was less turbulent it was clear that a number of issues still had to be resolved. These included the nature of the relationship between the management committee, the co-ordinator and the staff and the meaning of the objective of offering women a choice of therapies to deal with their problems.

The appointment of the fourth co-ordinator raised a number of issues for the management committee. The person finally appointed had previously been the nursing unit manager of a government detoxification service with a strong disease model basis. She also had a degree in women's studies and was sympathetic to offering women a range of therapies. For a variety of reasons the fourth co-ordinator found the demands of the position affected her health and offered her resignation after a few months. This was clearly a time of turmoil for the agency

and the choice of the next co-ordinator and drug and alcohol counsellor were vital to the on-going success of the service.

The fifth co-ordinator in two years was seconded from a government drug and alcohol treatment service. She was a registered nurse with extensive drug and alcohol experience, a particularly good rapport with children and an easy-going interpersonal style. She was seconded for six months and was later officially appointed to the position. The drug and alcohol counsellor appointed just prior to the co-ordinator was a registered nurse with a Masters degree in education and extensive health education and counselling experience. She was employed because she wished to provide an alternative to the disease model of addiction.

At this point in the history of the service the evaluation commenced.

CHAPTER 4 Jarrah House: The Treatment Process

4.1 The Treatment Process

It is important to include information about the structure and process of a treatment service, in addition to the outcome of the treatment itself.[1,2]

In order to be able to interpret the quantitative treatment outcome information, it was necessary that the evaluator spend a reasonable amount of time observing the treatment process. Accordingly, when testing whether or not there is an improved treatment outcome for women attending a specialist alcohol and other drug service, it is imperative to discover whether the program is in fact delivering the type of service described in its aims and objectives.

As part of the process evaluation, the researcher spent up to eight hours per week for nearly two years at the treatment service. Information was gathered by talking to the staff and clients on an informal basis and attending group discussions, staff change-over reports, staff meetings and management committee meetings. These experiences form the basis of this chapter of the report.

4.1.1 Physical Environment

Jarrah House is situated on the corner of a busy main road and a residential street in a light industrial and residential suburb of Sydney, opposite a local district hospital. The double-storey brick building has a small enclosed yard with a sand pit and play equipment, and is surrounded by a hospital car park. The downstairs area has a divided kitchen area, a playroom, a very small office for the co-ordinator and all other staff to share, a bathroom, a toilet, two childrens bedrooms and a very large room used for group discussions, dining and general recreation. On the second storey are four twin bedrooms for the detoxified clients, two detoxification bedrooms with attached nurses' observation area, a bathroom with laundry facilities, and a small office for visiting professionals (which is primarily used by general practitioners and the masseuse).

The decor is warm and homely with carpet in most areas and pleasant curtains and lounge furniture. There are posters of women's achievements and art work done by the school-age children on the walls. The lounge room is dominated by wall hangings outlining the 12 steps and 12 traditions of Alcoholics Anonymous.

4.1.2 Aims and Objectives of Jarrah House

The philosophy of the management committee is expressed in the aims and objectives of the service. These were initially outlined in the funding submission and remain unchanged.

Jarrah House Treatment Process

AIMS

1. To encourage women to seek early intervention for alcohol and other drugs/dependence problems.
2. To meet the diverse needs of women by the provision of a broad range of treatment options.
3. To minimise the factors contributing to the under-utilisation of alcohol and other drugs services for women.
4. To reduce the drop-out rate traditionally seen in women in treatment.
5. To provide an appropriate statewide service.

OBJECTIVES

1. To provide a 24-hour service to meet the detoxification needs of alcohol and other drug dependent women (and their children).
2. To provide a safe environment in which women can physically withdraw from alcohol and other drugs.
3. To provide a short-term residential rehabilitation programme for women and their children, following detoxification.
4. To provide both individual and group therapy according to the specific needs of each woman.
5. To provide accurate community service information (legal, health and welfare) to both resident and non-resident women.
6. To provide follow-up support services (e.g. ongoing counselling, assistance with housing).
7. In conjunction with the clients, to provide the children with appropriate care and referral to other agencies.
8. To offer information and referral services to the families of resident women at the request of those women.
9. To liaise closely with other health and welfare services.
10. To monitor closely the extent to which the objectives of the centre are being met.

4.1.3 Admission Procedure

Jarrah House provides a service for up to thirteen women and six to eight children under 8 years of age. Women are initially screened by telephone to exclude those considered unsuitable for admission. The exclusion criteria include:

1. Significant current physical or psychiatric health problems.
2. Women requesting selective detoxification (e.g. remaining on methadone while coming off benzodiazepines).
3. Poor motivation, as indicated by a large number of previous admissions. Clients may not be admitted if they have left another agency within the last seven days nor may they be re-admitted within 30 days.
4. Clients may be on bail, parole or probation but will not be admitted if they have a scheduled court appearance during the proposed admission.
5. Pregnant opiate addicts are referred to a Drugs in Pregnancy Program.
6. The age limit is between 14-16 years if suitably mature and places are not available in an adolescent program.
7. Transexuals.

When accepted, the client is given a summary of the house rules and advised of the fees. These are assessed individually, but average $40-60 per week for each woman and $10 per week for each dependent child. Clients are also told that since welfare workers are not available they should make all welfare and housing arrangements prior to admission.

Following the telephone screening procedure, an appointment is made for interview. The intake questionnaire is wide ranging and covers demographic details, drug and alcohol history, treatment history, medical details and life experiences (employment, abuse, relationships, etc.). The woman and her belongings are searched on admission and she is advised of the following rules:

- No alcohol or other drugs to be used.
- No verbal or physical abuse of clients, children or staff.
- No sex while at the unit.
- Smoking only permitted in the lounge room or outside the unit.
- All aspects of the program are compulsory.
- No phone calls for the first 5 days.

- No visitors for the first 10 days.
- No leaving the unit for 14 days.
- Visiting hours Wednesday and Friday for 1 hour between 5.30 and 7.30 p.m., Wednesday 1.30 - 2.30 p.m., Sunday 3.00 - 5.30 p.m.
- Visitors not to be intoxicated.
- Everyone is expected to contribute to household chores as per roster.
- TV and stereo to be turned off by 11 p.m.
- Childcare is only provided during detoxification and group time, clients are expected to care for their children at all other times.

The women are given a choice of medicated or non-medicated detoxification and are advised that although the program may last for up to six weeks, their discharge date will be decided in consultation with their counsellor. The staff member who admits the client is deemed to be their primary counsellor. However, as there were a large number of part-time staff, continuity of primary counsellor was not always possible.

4.1.4 The Program

Over the period of the evaluation the program changed very little. The following is an outline of the clients' weekly activities (Table 4.1). In the community meeting the clients affirm their status as an alcoholic and/or addict, reiterate any relevant rules and discuss any sources of tension between residents and staff or between the residents.

The morning group was run by the drug and alcohol counsellor. During the majority of the study this position was filled by a registered nurse with a Masters degree in education and experience as a gestalt therapist. This therapist made use of drawings and rôle plays to explore the feelings of the clients. Her groups focused on assertiveness training, conflict resolution, self-esteem and relationship issues in addition to specific substance use issues.

During the period of the evaluation this therapist resigned in frustration at the lack of support for staff or clients not willing to accept the disease concept of addiction. Even though this therapist did not undermine any tenets of the disease model she experienced great hostility from some staff members.

The second drug and alcohol counsellor employed during the study was a newly graduated psychologist-in-training, who was also employed to offer an alternative to the disease model. The Wednesday parenting group was conducted

Table 4.1

Jarrah House Treatment Program

TIME	MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY	SATURDAY	SUNDAY
7.00-9.30	Housework and Breakfast						
9.30	Community Meeting						
9.45-10.45	Yoga	Walk	Aerobics	Relaxation	Walk	Relaxation	Outing
11.00-12.30	Group	Group	Parenting Group	Group	Group	Group	
12.30-1.30	Lunch	Lunch	Lunch	Lunch	Lunch	Lunch	
1.30-2.30	AA meeting	Education	Visiting	Shopping	Massage	Free Time (playing with children)	Visiting
3.00	Reading	Reading	Reading	Reading	Reading		
3.30-4.30	Group	Group	Group	Group	Group		
4.30-	Choice of AA, NA Meetings or Individual Counselling						Free Time

by the childcare workers and explored such issues as appropriate discipline, limit setting, and dealing with guilt over previous lapses in parenting.

The program slot marked 'education' was principally used for women's health education, including breast examination, AIDS and STD education, and discussion about contraception. The reading time was devoted to AA/NA literature and the afternoon group was teaching and discussion of 12-step concepts. A related topic that was also discussed was the concept of co-dependency which was defined as a chronic, progressive disease that is characterised by denial, ill health or maladaptive behaviour, and by a lack of knowledge about alcoholism. The clients were informed that co-dependence was rife among the 'helping' professions in whom it is characterised by the failure to make a diagnosis of alcoholism, and by the belief that those with alcohol-related problems can be successfully treated by professionals.

Following the three weeks of compulsory, daily 12 step-meetings the client was theoretically free to choose whether she continued attending. The conviction with which the disease model and 12-step programs were discussed by the majority of staff members made it unlikely that many clients would decide not to attend evening meetings, especially as this was a significant source of social contact. While the few staff members that did not adhere to the disease model did an excellent job of addressing other issues, the clients were not offered any coherent alternative theoretical account of substance dependence with appropriate clinical techniques.

4.1.5 Staff Relations

While the majority of the staff lacked any formal training in the treatment of addictive disorders, they were generally caring and hard working. The majority accepted the disease model and 12-step approach to treatment. Observation of staff meetings and shift-change reports highlighted the tensions that persisted between the staff in the service that had a brief to offer a variety of treatment options. These tensions unavoidably affected client care. They also led to staff resignations. For example, the drug and alcohol counsellor resigned because of her inability to have sexual assault issues addressed for appropriate clients, and the efforts of some staff to undermine the choice of alternative therapies. Her reasons were set out in an explanatory letter to the WADAC committee.

Staff conflict did not end with her resignation. The newly appointed drug and alcohol counsellor was a psychologist-in-training and her youth and inexperience

crystallised the views of the staff members committed to the disease model. Despite her naturally empathic style and professional dedication to furthering her skills she was frequently attacked in staff meetings. For example, when she supported the view that women should not be discharged for an emotional outburst she was told: "You know nothing, only what you learn in a book" (sic), and: "there are fundamentals of addiction common to all addicts - they lie, manipulate and cheat and their word means nothing". These two comments give a flavour of the attitude of this minority group of staff who, by the force of their invective, managed to hold sway in staff encounters of all kinds. This drug and alcohol counsellor resigned after approximately one year.

The most common themes of the staff meetings during the period of the study were: (1) enforcement of client rules, for example, discharge for smoking, strip searching of clients on admission, tardiness and emotionality in group discussions; (2) payment for staff to attend clinical supervision or WADAC meetings; and (3) whether or not sexual assault issues should be dealt with as they arose, or by recommending that the client wait until she had achieved six months sobriety before receiving counselling.

4.1.6 Clinical Supervision

One way in which the management committee attempted to reconcile the on-going sources of conflict among the staff was to provide clinical supervision. Prior to the commencement of the study, this supervision was provided by a nurse-counsellor who was a member of the WADAC committee. The potential conflict of interest was recognised as the supervision was abandoned by the time the study began. After a few months an outside therapist in private practice was engaged who used a combined feminist, 12-step and psychodynamic approach to therapy!

4.1.7 In-Service Training

The level of in-service training activities was dependent on the enthusiasm of the co-ordinator and the drug and alcohol counsellor. The drug and alcohol counsellor employed at the time the study commenced organised a number of visiting speakers to address the staff but as her disillusionment grew, attempts at in-service training became more sporadic and were eventually discontinued.

4.2 *Concluding comments*

Jarrah House provided a professional and caring service for women with substance use problems and their children. There were, however, a number of issues that affected the program development and delivery. The issues that continued to arise for the management, staff and clients of Jarrah House were present from its inception. These were: the model of management to be adopted; the nature of the relationship between the management committee, the co-ordinator and the staff; and the employment of staff capable of matching the needs and desires of their clients for a choice among a variety of therapeutic approaches.

CHAPTER 4 References

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CHAPTER 5 Mixed-Sex Services: The Treatment Process

5.1 Wisteria House, Cumberland Hospital

Wisteria House (WH) is a traditional mixed-sex treatment service located in the western suburbs of Sydney. At the time of the study it was set on the banks of the Parramatta River in the beautiful grounds of a large psychiatric hospital. The program ran on a medical model with largely professional staff, including a psychiatrist as the Director of the service, resident medical officers, a psychologist, a social worker, two specialist drug and alcohol counsellors, with the rest of the staff being made up of registered nurses. Wisteria House offered a three week residential program for up to twelve clients with addiction problems. It also treated clients with gambling problems and conducted selective detoxification for clients who wished to remain on methadone (such clients were not included in this study). The treatment philosophy was the disease model, with induction to 12-step programs being emphasised as vital to recovery. Abstinence was the only goal of therapy offered (although selective detoxification clients remained on methadone). The conventional rules forbidding the use of psychoactive substances, sex and violence applied to the clients of the service.

5.1.1 Detoxification

The treatment program comprised two stages, detoxification and the short-term residential program. Clients were always admitted to the detoxification area, which was located in a demountable building with two dormitories where staff could observe the clients closely. The clients were admitted by a nurse and a resident psychiatric registrar, but very little information was recorded concerning drug use, treatment or life experience history. Progress notes were written only weekly once clients left the detoxification ward. As a result, the researcher provided a female admission questionnaire in order to gather appropriate information on clients who left treatment prematurely. Typical detoxification care was provided, including vitamin therapy and reassurance, and regular physiological observations with clients being given medication if they manifested withdrawal symptoms.

5.1.2 The Program

Following detoxification, those clients who requested, and who were judged by staff consensus to be suitable for the program, moved to an adjoining two-storey house. The accommodation in this building was in same-sex bedrooms of between two and six clients with bathroom facilities that were shared with male

Table 5.1

Wisteria House Treatment Program

TIME	MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY	SATURDAY	SUNDAY
7.00	Daily Commitment					WEEKEND LEAVE AVAILABLE TO CLIENTS AFTER 7 DAYS	
8.30	Breakfast						
9.00	12-Step Readings						
9.40	Organisation & Rules Group						
10.00	Morning Tea						
10.30	Group Discussion	Activities	Group Discussion/ Community Counsellor	Group Discussion/ Psychologist	Group Discussion/ Social Worker		
11.30	Group Discussion	Group Discussion	Activities	Activities	Activities		
12.30	Lunch Leave						
1.00	Lunch						
2.00	Group Discussion	Group Discussion	Group Discussion/ Clergy	Activities	Group Discussion	AA Meeting	NA Anon
3.00	Afternoon Tea						
3.30	Group Discussion/ Social Worker	Group Discussion/ Psychologist	Group Discussion	Group Discussion	Activities	Free Time	Free Time
5.00	Dinner						
Evening	AA/NA Meeting	STEPS Meeting	AA/NA	AA	NA/AA/GA		AA/NA Christian Life Centre

clients. There was less staff supervision for the program clients, and when there was only one female client they were allowed to sleep in the detoxification area if they were afraid to be alone with the male clients (as was often the case).

There appeared to be three main components of therapy (Table 5.1): induction to AA/NA/GA philosophies and attendance at meetings; review of psychosocial concerns such as anger and relationship issues; and follow-up services addressing self-esteem and family counselling. The two specialist drug and alcohol counsellors provided the majority of AA/NA induction and both had moving and inspirational personal stories of recovery to relate. They were non-confrontational (in the main) and extremely professional in their approach.

5.1.3 Group Discussion

The social worker conducted group discussions and activities looking at family issues and dealing with emotions. The psychologist provided similar groups with one important difference. This therapist ran a group called the "Hot Seat" three times per week. While this group was not compulsory there was significant peer pressure to participate prior to discharge from the program. The group began with the client reading out a speech asking for the groups' support and claiming that "Deep down I fear I am nothing" and that they "Fear loss of love". This speech was extremely confronting and required a high standard of literacy that proved a source of embarrassment to many clients. The aim of the group was to compare the clients "fronts" with their real qualities. Female clients were particularly anxious about this group as issues of guilt and shame (particularly concerning their children) were dwelt upon. Although the psychologist who conducted this very confronting group was sensitive and professional, there are concerns about the imminent discharge of clients who have been induced to publicly acknowledge such painful material.

5.1.4 Spirituality

An unusual aspect of this program was the additional involvement of religious education. There was a weekly one-hour group conducted by a Roman Catholic priest or a member of the Anglican clergy. This group was intended to introduce the client to aspects of spirituality required for an understanding of the AA/NA/GA philosophies. In addition to general discussion of spiritual aspects of the self-help groups, clients were offered an introduction to a local Pentecostal

church known as the 'Hills Christian Life Centre' where some staff members attended services.

5.1.5 Individual Counselling

While a wide variety of group discussions were offered, individual consultations with staff members were suggested to clients and were always available on request.

5.1.6 Physical Activities

Once clients had recovered from the physical effects of detoxification, physical activities were an integral part of the program. These activities took the form of team sports such as touch football and volleyball, aerobics classes and swimming in the summer months. Indoor games such as *Trivial Pursuit* and *Monopoly* were also offered.

5.1.7 Education

Discussion groups sometimes touched on HIV/AIDS information, but there was no systematic education on this or other health-related topics.

5.1.8 Out-Patient Services/Outreach

Wisteria House offered an extensive out-patient service, including a thirty session general out-patient group where general life and recovery issues were addressed. There was also a self-esteem group and a family out-client group. There was a very supportive atmosphere and an emphasis on participation in an out-client group. These services required a great deal of the therapists' time and effort and often involved unpaid overtime.

5.1.9 Staff Relations

Wisteria House appeared to have a very harmonious and well integrated staff. As part of a larger institution with traditional hierarchical staff relationships, staff were in no doubt as to their role and level of responsibility in the organisation. Staff at all levels were respected as members of the team and had equal opportunity to comment on a clients' progress. While the disease model was the prevailing model of substance dependence used, staff members were amenable to other views (but these alternative models of treatment were not available to the clients).

5.1.10 In-Service Training

There were regular in-service lectures, that included invited speakers from relevant community agencies. General alcohol and other drug issues, and the special needs of particular client groups were discussed during such sessions.

5.2 Concluding Comments

Wisteria House appeared to be a well-integrated and professionally run treatment service. The unit allowed clients to have lunch-time and week-end leave in which to organise their lives and to practise some of their newly acquired skills. The majority of the staff were empathic and clients were respected as individuals. As a result the staff and clients both appeared to value their time at Wisteria House.

5.3 Ward 4, Mosman District Hospital

The second of the traditional mixed-sex treatment services was located in a middle-class area of Sydney's lower north shore. At the time of the study the service was set in a large two-storey house with a small garden in the grounds of a private general hospital. While it had administrative links to a large general hospital, in practice it was largely autonomous. This program offered admission for fourteen clients, but limited the number of beds available to persons with opiate problems to five.

Ward 4 was staffed by approximately equal numbers of registered or enrolled nurses and untrained people who were recovering from their own substance dependence problems. The service co-ordinator was a registered nurse and the service appeared to operate within a typical medical model. The conventional rules forbidding the use of psychoactive drugs, sex and violence applied to the clients of the service.

The treatment philosophy was the disease model with induction to 12-step programs emphasised as vital to the client's successful recovery. Abstinence from all psychoactive substances was the only goal of therapy offered. Clients stayed for seven days on average, but the length of stay varied depending on the clients' condition.

5.3.1 *Detoxification*

Clients were first accommodated in the downstairs section of the house for closer observation. They were admitted by a member of staff and an extensive personal, medical, substance use, treatment and life history was taken. This assessment instrument was developed by a psychologist from the Area Health Region and was well beyond the skills of the vast majority of staff members to accurately administer (for example it required DSMIII-R diagnosis of Eating Disorders without information on the classificatory criteria).

Clients were seen by a medical officer within 24 hours of admission and referral was offered to specialist services where required. Ward 4 offered a traditional non-medicated detoxification, with regular physiological observations, vitamin therapy and reassurance. The use of minor analgesics and other medication was discouraged and psychoactive medication was only offered in life-threatening situations. If serious withdrawal symptoms were demonstrated, clients were transferred to the care of a public, general hospital.

5.3.2 *The Program*

Daily instruction in 12-step programs was provided by an elderly member of Alcoholics Anonymous. This man had a moving and inspirational personal story of his experiences of alcoholism and the process of recovery to recount to the clients. He also covered two steps of the twelve step program each week-day morning. The style was didactic and non-confrontational but the content emphasized the beliefs of many AA members about the genetic and physiological basis of alcohol dependence (e.g. that alcoholics have an enzymatic disorder that induces craving and loss of control over drinking, if even one drink is taken). The personal charisma of this man touched the majority of clients and he was frequently cited by clients as a source of inspiration.

5.3.3 *Group Discussion*

In addition to 12-step induction, daily discussion groups were held in the afternoons (Table 5.2). All clients who were not seriously unwell or still intoxicated were required to attend these groups. As a result, group members were in various stages of physical or emotional discomfort. This discussion group was run as an encounter group. Two staff members led the group which began with a relaxation exercise involving progressive muscle relaxation. This was usually

Table 5.2

Ward 4 Mosman Treatment Program

TIME	MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY	TIME	SATURDAY	SUNDAY
8.30-9.00	* Walk	* Walk * if well	* Walk enough to	* Walk participate	*Walk	8.30-10.30	House Duties and Walk	House Duties and Walk
9.00-10.00	Exercise/ Relaxation	Exercise/ Relaxation	Exercise/ Relaxation	Exercise/ Relaxation	Exercise/ Relaxation	10.30-12	Discussion	Discussion
10.45-12.15	AA Induction	AA Induction	AA Induction	AA Induction	AA Induction			
12.15-1.00	Lunch	Lunch	Lunch	Lunch	Lunch	12-1.00	Lunch	Lunch
1.00-2.00				AA/H&I Meeting				
2.30-4.00		Discussion		Discussion		2.30-3.30	Video/Film	Video/Film
3.30-5.00	Discussion		Discussion		Discussion			
5.30-6.00	Dinner	Dinner	Dinner	Dinner	Dinner	5.30-6.00	Dinner	Dinner
6.00-7.30					NA Meeting			
8.00-9.30			AA Meeting			8.00-9.30	NA/H&I Meeting	

followed by a prolonged and uncomfortable silence as the co-leaders waited for a client to speak. Some of these groups were highly confronting for the clients with an emphasis on their frequent and varied past failures. The ambience of the group depended on the training and philosophy of the leaders. For example, some staff members did not prevent vulnerable clients being exploited by the group members, and some untrained staff members attempted psychoanalytic interpretations on the basis of minimal contact with the client in this group setting. These groups were unpopular with clients and did not appear to follow any systematic therapeutic approach, or to have any clear goal.

5.3.4 Relapse Prevention

A visiting cognitive-behavioural psychologist from the Area Health Region offered one relapse prevention session per week. This was the only session wherein clients were exposed to skills-based training about drink refusal and the management of lapses into substance use. The clients appeared to have difficulty relating the two treatment philosophies of disease and social learning models.

5.3.5 Individual Counselling

Individual counselling was not encouraged (and occasionally actively discouraged) but it was generally available if requested. Clients upset by discussion in the encounter style discussion group often requested individual counselling after the group to deal with the painful issues raised in so public a forum.

5.3.6 Physical Activities

Morning walks for those clients who were well enough and occasional tennis games or other physical activities were provided. As there was a large amount of free time in the program, the clients frequently expressed a desire for more structured activities

5.3.7 Education

Once a week a community HIV/AIDS educator visited the unit. These sessions often ran in the form of games and discussion.

5.3.8 Discharge Services

Only referral to AA/NA was offered after discharge. There was no formal out-client program, although on a few occasions clients continued to attend for individual counselling following discharge.

5.3.9 Staff Relations

On the whole, the staff of the unit provided a caring and professional service. While staff relations were generally harmonious, there appeared to be some discord between those who worked in the disease model of addiction and those who had a more eclectic approach.

5.3.10 Clinical Supervision

A number of senior staff members had private clinical supervision provided by a psychoanalytic therapist in the area. The appropriateness of such a model for the training of staff members was unclear since the program provided short-term detoxification service with no out-client program, and it usually attracted a socio-economically disadvantaged and severely substance dependent group for whom long-term and expensive psychodynamic therapy would seem of doubtful value.

5.3.11 In-Service Training

The unit provided no on-going in-service training for their staff.

5.4 Concluding Comments

Ward 4 provided a basic short-term detoxification service. The majority of the staff were dedicated and caring and were responsive to clients' needs. However, as a result of clients' physical discomfort, the extended amounts of "free" time and the unstructured encounter group style, the atmosphere was not always conducive to client or therapist optimism.

CHAPTER 6 Description of Client Characteristics

6.1 Demographics[a]

For the total sample, the age of the women at the time of admission ranged from 18 to 66 years, with median of 32.5 years in the specialist women's service, Jarrah House (JH) and 33.5 years for the two traditional mixed-sex comparison services (CS). These figures are consistent with reports that women present for drug and alcohol treatment at a younger age than men, and that the 30s is the period of highest risk for alcohol related problems in women.[1,2]

About 48% of the total sample were single, 8% were married, and 11% were in de-facto relationships. There were no significant differences between the two treatment groups on these variables. Over the three treatment centres, the women were significantly more likely to be single than to be in a stable relationship (co-habitating with a sexual partner). The total sample of clients had moved a median of 6 times in the preceding six months, and forty five percent of the sample were of "no fixed address", that is, they did not have a home address but were consistently moving between the houses of friends and relatives and between various institutions. Women attending Jarrah House were most likely to report living alone with their children (21%) and women attending the Comparison Services were most likely to report living with their partner and children (22%).

In this study the percentage of women in a stable relationship is lower than that cited in similar studies[3,4,5] and is much lower than that of women in the community in this age range[5] or of men in alcohol and other drug treatment.[4] This may be because men are less tolerant of their female partner's substance abuse, and are more likely to leave the relationship than are female partners of male substance abusers.[6] Alternatively, it may be that women who have reached a crisis in their relationships are more willing to submit themselves to the potential discomfort of substance dependence treatment. Although the nature of the casual relationship is unclear, it is likely that the lack of stable relationship is related to the mobility of the sample. The finding that 45% had no fixed address, highlights the most basic welfare needs of these women and points to the difficulties encountered in the follow-up of this client group.[7]

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[a] *Statistical Analyses: In an attempt to provide a reader-friendly account of the large amount of data collected in the study, we have only included descriptive statistics in the text. Those interested in the results of the inferential statistical procedures are directed to appendices where appropriate. Introductory comments on types of analyses employed may be found in Appendix D. When we use the term 'significant', it may be read as statistically significant using the appropriate test.*

Women attending Jarrah House (21.3%) were more likely to be lesbian than were women attending the Comparison Services (6.3%) (Figure 6.1). A further 6.3% of women in both treatment services identified their sexual preference as bisexual. Lesbian women were significantly more likely to be in their first substance abuse treatment than were heterosexual or bisexual women.

The significantly larger proportion of lesbian women attending Jarrah House is noteworthy. Many authors have suggested that lesbian women have a higher incidence of drug and alcohol problems than heterosexual women[8-10] although the reason for this is unclear[11]. The finding that a bisexual or lesbian orientation independently predicted attendance at Jarrah House suggests that the ability of a gender-sensitive service to attract these women into treatment is very important. (Please see Appendix D for results of the statistical analysis.)

6.2 Children

The total sample reported a median of four pregnancies, and fifty five percent of the women in the study were mothers. Women attending Jarrah House were more likely to have dependent children (54%) than were women attending the Comparison Services (35%).

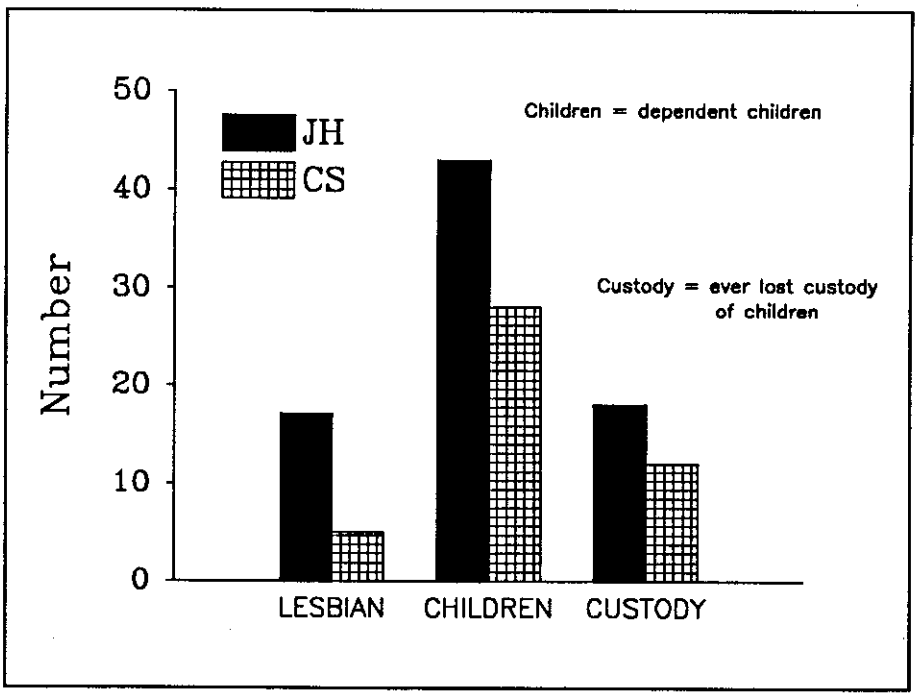
Women with dependent children who attended the Comparison Services most frequently reported that their children were cared for by the father (17.5%) or grandparent (12.5%). Only 3.8% required foster care during the period of the mother's admission. Subjects attending Jarrah House (22.5%) were also more likely to have lost custody of a child (either temporarily or permanently), than were women attending the Comparison Services (15%).

It was consistent with the aims of the agency, that significantly more women with dependent children were attending Jarrah House than the Comparison Services. Studies in the USA of demonstration specialist women's services have also reported an increase in the recruitment and retention of women with dependent children in services that provide childcare[3].

The particular parenting concerns of women with drug and alcohol problems are rarely addressed in traditional mixed-sex treatment services.[12] The magnification of existing feelings of guilt, shame and failure surrounding their maternal role, if left unaddressed, may negatively affect treatment outcome. The adequacy of substance abusing women as mothers has been questioned[13] and the legacy of dysfunctional child-rearing patterns for the child may be malnutrition, developmental delays, learning disorders and future substance abuse[14]. Therefore,

the ability of the Jarrah House program to attract a higher percentage of women with dependent children, and those with the additional stigma of having lost custody of their child, suggests that it is filling a treatment need for women that is unmet in traditional mixed-sex programs.

Figure 6.1 Demographic Characteristics by Type of Treatment



6.3 Crime

Thirty eight percent of the women in this sample had been involved in some type of criminal activity, the most frequent of which were property crime (25%) or fraud (9%). The total sample reported a median of six convictions, and a median of 5 months in prison or juvenile institution to the time of admission. Although all of the services in the study stated that they did not accept clients who had court cases pending, 2% of the sample were currently on bail. A further 11% were currently on probation or parole. There were no significant differences between the two groups on these variables.

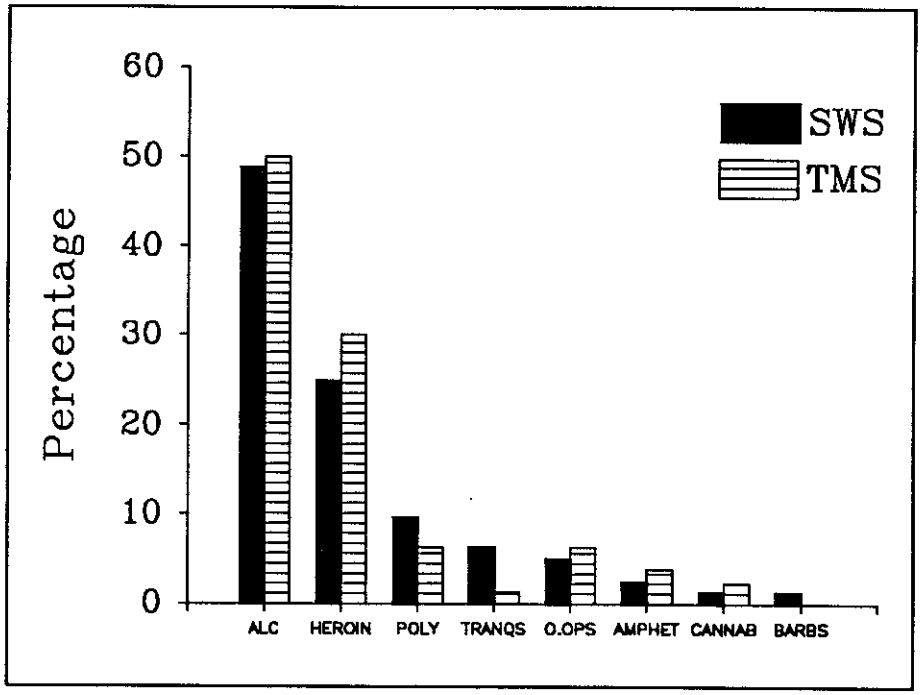
6.4 Employment

Subjects had completed a median of 3 years of high school. During the 6 months prior to admission, 53% of the women were in full or part-time employment. At the time of presentation, however, 51% reported that social security benefits were

their primary source of income. Their principal occupational groupings were: unskilled (28%), office skills (23%), and hospitality services (19%). The largest professional group was nurses (Jarrah House 15% & Comparison Services 9%). Thirty seven percent reported holding no formal employment qualifications, 22% had secretarial qualifications, 15% had a diploma, 10% had trade qualifications, 9% had qualifications in bar tending and food service and 7% held a tertiary degree. There were no significant differences between Jarrah House and the Comparison Services treatment services on any of these variables.

6.5 Drug and Treatment History

Figure 6.2 Drug of Choice by Type of Treatment



There were no significant differences in the drug of choice reported by the clients of Jarrah House and the Comparison Services (Figure 6.2). Alcohol was most frequently the primary problem drug for clients of both centres, accounting for around 50% of admissions. Heroin was cited as the problem substance for between 25% and 30% of clients in the sample. The substance that the subjects reported as their drug of choice is reported here, although many of the clients substituted and supplemented their drug of choice with other substances and used other drugs opportunistically. Subjects were classified as poly-drug abusers only

if they used a number of drugs with relatively equal frequency. Women attending Jarrah House appeared to be require a more complicated detoxification, as there were forty percent more poly drug users, many more women addicted to benzodiazepines and a small percentage (1.3%) of women with addiction to the barbiturate analgesic, nembudeine, attending that centre.

The most frequent reason reported by subjects for initiating their substance abuse was to forget family problems (45%), which frequently included their partner's substance abuse. A further 26% reported that drugs or alcohol increased their social confidence, 15% cited peer pressure, and others gave reasons such as the excitement of the experience, depression and physical pain.

The median period of problem drug use was 10 years. For alcohol dependent women, the mean dependence score as measured by the SADQ was 32 which falls within the severely dependent range. For those who were primarily opiate dependent, the mean dependence score as assessed by the SODQ was 33, which also falls within the severely dependent range. There were no significant differences between the women attending the two treatment groups on either measure of dependence.

Forty seven percent of women attending Jarrah House and 45% of those attending the Comparison Services were in their first substance abuse treatment. The overall median number of previous treatments was five. About half the sample had little or no previous involvement with 12-step programs, while 25% had attended more than eighty Alcoholics or Narcotics Anonymous meetings prior to admission.

6.6 Factors Affecting Service Choice

Subjects were asked whether or not they agreed that: "Society looks down more on women who have a problem with drugs or alcohol than it does on men with the same problem". Eighty four percent of the subjects agreed with the statement and 48% of subjects reported that they had delayed seeking treatment because of the stigma attached to the label of "alcoholic" and "addict". This finding has clinical implications given that all three programs required their clients to accept the label of alcohol or addict and to identify themselves as such daily in a group setting.

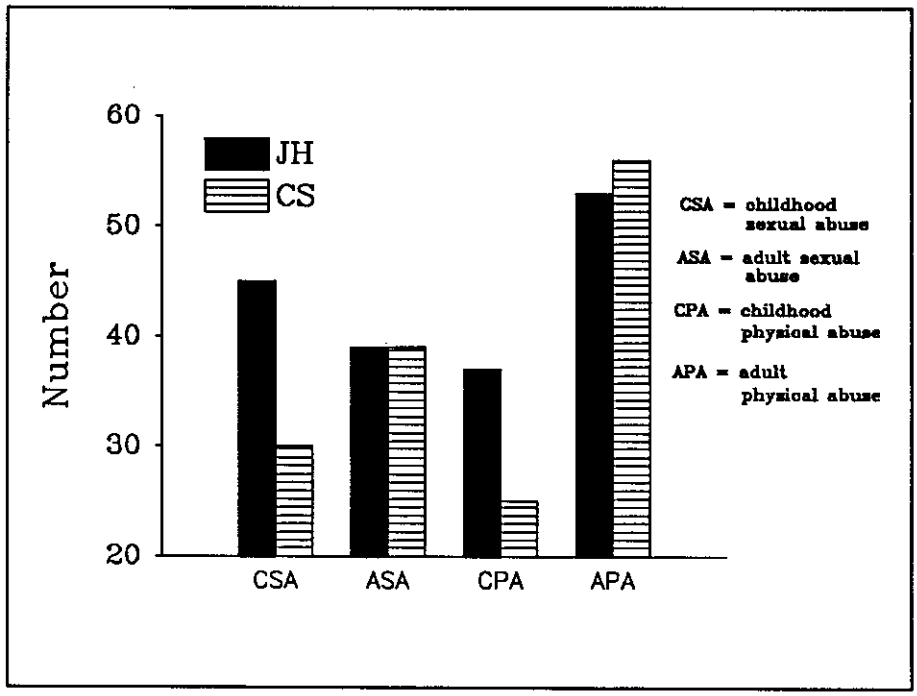
The most common mode of referral into treatment was via another drug and alcohol treatment agency for women attending Jarrah House, and via a friend or relative for women at the Comparison Services. The most frequent reason (24%) given for seeking admission at this time was concern that they had lost control

over their substance use. When asked why they had attended that particular service, the two most common responses of subjects at Jarrah House were because it was a women-only service (39.5%) and that it offered residential childcare (33.3%). Clients at the Comparison Services reported that it was the only option presented to them by referring agencies (28%) or that it was close to their home (21%).

6.7 Life experiences

Of the total sample of women in the study approximately 50% had been sexually abused in adulthood, 68% had been physically abused in adulthood and overall around 86% had experienced sexual and/or physical abuse at some time in their lives (Figure 6.3). Lesbian women were significantly more likely to report sexual abuse in childhood than were heterosexual or bisexual women.

Figure 6.3 Lifetime History of Sexual/Physical Abuse by Type of Treatment



Lesbian and bisexual women were also significantly more likely to report sexual abuse in adulthood than were heterosexual women. Women who had been sexually abused in adulthood were significantly more likely to be in their first drug and alcohol treatment than were women with no such history. This may be because the experience of sexual assault, frequently in the domestic setting, may

make such women more aware of their vulnerability to attack when intoxicated. A further reason for seeking assistance for substance use problems at this time maybe the physical safety of the treatment setting.

Women attending Jarrah House were more likely to report sexual abuse in childhood than were women attending the Comparison traditional mixed-sex Services. In the case of physical abuse in childhood, the difference between Jarrah House (37%) and the Comparison Services (25%) narrowly failed to achieve statistical significance. Accordingly, it would be unwise to infer that there is no difference between women in Jarrah House and the Comparison Services in their histories of physical abuse in childhood.

Thirty percent of the subjects had worked in the sex industry at some time in their lives. Women with a history of prostitution were significantly less likely to be in their first treatment than were women who had never worked as prostitutes. This over-representation of women who have worked in the sex industry (who in turn were more likely to have a history of childhood sexual abuse than were women who had never worked as prostitutes) among repeat treatment-seekers may be explained by a heightened sensitivity to sexual harassment and social stigma in a mixed-sex treatment setting.

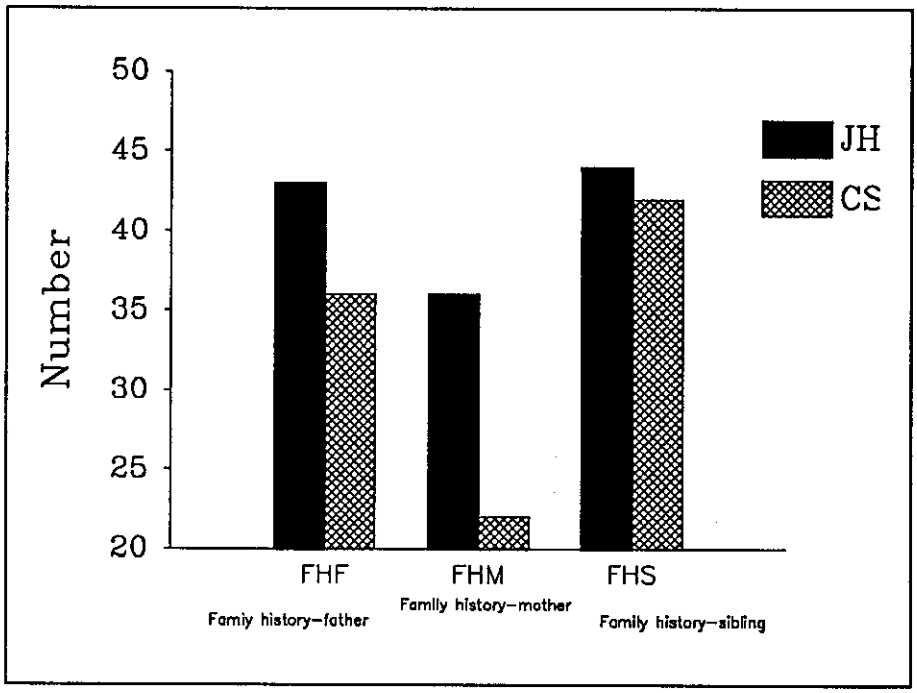
The incidence of childhood sexual abuse among women in this sample is consistent with that reported in the literature on women with substance abuse disorders, and substantially higher than that reported among men in treatment.[6,15]

The increased incidence of childhood sexual abuse among women attending Jarrah House suggests that physical safety may be of particular concern for many women in treatment. While women with a recent history of abuse share similar concerns about physical safety, women who have been sexually abused in childhood (particularly incest survivors) appear to have a strong need for a physically and emotionally safe environment as their trust has been seriously violated in the past.[16] Three of the groups of women who are traditionally considered difficult to recruit and retain in substance abuse treatment - lesbian women, sex workers and women under 25 years[3] - were all found to be significantly more likely to have experienced childhood sexual abuse in this study. It appears that having a history of sexual abuse, particularly in childhood, is a salient treatment issue for Sydney women with substance abuse problems, and the ability of a specialist women's treatment service to attract such women is of great potential importance.

6.8 Family History

Around 50% of the total sample had come from a family in which the father had a problem with alcohol or drug abuse, and about half of the sample had one or more siblings with substance abuse problems (Figure 6.4). There were no significant difference between the two treatment services on these variables. However, women attending the Jarrah House were more likely to have a mother with a history of drug or alcohol problems than were the women attending the Comparison Services.

Figure 6.4 Family History of Substance Use Problems by Type of Treatment



Whether one subscribes to genetic or social-learning based theories of addictive disorders, the role model for substance abuse and parenting practices with which the women in this sample were provided is reflected in the extremely high rate of familial drug and alcohol problems. Clinical studies report alcoholism in a median of 40% (range 24-46%) of the fathers and 8% (range 0-20%) of the mothers of female alcoholics.[17,18] The estimate of paternal family history in the sample is consistent with that in the literature but the estimates of maternal alcoholism in the present sample are much higher than those in the literature. The high rates of custody loss may be related to the high incidence of maternal substance abuse in the Jarrah House group.

6.9 Psycho-Social

The mean Beck Depression Inventory (Short Form) (BDI) score for women attending the Jarrah House was 23 and the mean BDI score for women at the MS was 21. The cut-off score for extremely severe clinical depression on the BDI is 19, and 77% of the sample fell into this range. In addition, between one half and two thirds of the sample had attempted suicide at least once. The mean self-esteem scores as measured by the Coopersmith self-esteem scale were 27 for Jarrah House and 33 for the Comparison Services. The normative score for women on the Coopersmith is 70, across age and ethnicity.

There were no significant differences between Jarrah House and the Comparison Services on Beck Depression Inventory scores or the Coopersmith self-esteem scores. Nor was there any statistically significant difference in the proportion of women attending the two type of treatment service who had attempted suicide. However, the confidence intervals around the difference in each case suggested that women from Jarrah House may be more depressed with lower self-esteem and a greater history of parasuicides than women attending the Comparison Services. (Appendix D for details of the statistical analyses.)

6.10 Comments

This sample of women in substance abuse treatment had serious psychological and social problems. They were most commonly depressed and had low self-esteem. Lesbian women and women with a history of physical or sexual abuse were over-represented, as were those with a family history of substance abuse problems. These women were socially isolated, had limited vocational skills and were often severely dependent on psychoactive drugs.

This comparative examination of the characteristics of women attending Jarrah House or the Comparison Services has revealed that men and women in residential treatment for drug and alcohol problems have similarly extensive social problems of unemployment, broken relationships and unstable places of residence.[19] However, the women in this study had the additional problems of dependent children, serious parenting deficits and psychological and personal safety issues concerning their experience of physical and/or sexual abuse.

The evidence that a different clientele attend Jarrah House than the Comparison Services, specifically women with a history of sexual abuse, parenting concerns and/or an awareness of sexual politics, suggests that specialist women's services may fill an important gap in the existing traditional mixed-sex treatment services

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by attracting a group of women into treatment who are traditionally reluctant to present.

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CHAPTER 7 Impact Evaluation

7.0 Introduction

An impact evaluation is concerned with the immediate effects of the treatment service and, more specifically, with the measurement of the degree to which the programs' objectives are realised.[1] By comparison, outcome evaluation, which is discussed in the following chapter, is concerned with the longer term effects of the program, and usually corresponds to the program goal.

Before investigating the longer term effects of a treatment, it is necessary to establish that its short-term impact is appropriate. Do women stay in treatment long enough to receive any benefit? Does admission to treatment improve their psychological and physical well-being? This chapter discusses the issue of drop-out from treatment and whether or not the Jarrah House program had an effect on the rate and pattern of this common occurrence in many substance use treatment programs. The clinical status of clients at discharge is also reviewed to assess the short-term effects of the program on depression and self-esteem and to explore the levels of satisfaction with each of the treatment services.

7.1 Treatment Drop-Out[a]

7.1.1 The Relevance of Treatment Drop-Out

The high incidence of treatment drop-out for clients with drug and alcohol problems is of great concern to researchers and clinicians. Treatment drop-out rates in excess of 50%, across a variety of treatment modalities, are not uncommon.[2,3] The apparent inability of treatment providers to engage and retain the majority of clients with substance dependence problems, makes it highly desirable to identify those people who might be expected to benefit most from a particular treatment.

Although drop-out rates for women have been reported as twice that for men,[4] the consensus is that women are no more prone to treatment drop-out than are men.[5] While as a group women may not be more susceptible to premature termination of treatment, there has been minimal research on the identification of predictors of treatment drop-out for women. No research has been conducted on the impact that specialist drug and alcohol treatment services for women might have on treatment drop-out.

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[a] *See Appendix E for details of statistical analyses*

The major aim of this part of the study, therefore, was to compare the characteristics of women who stayed less than 5 days in treatment with those of women who stayed more than 5 days and whether or not the type of treatment service the client attended affected this pattern. The central questions of interest were: In what ways do women who drop-out of treatment differ in terms of socio-demographic characteristics, sexual orientation and number of dependent children? Do the groups differ in terms of drug use, treatment history and psycho-social issues, such as a history of sexual abuse? In addition, does a specialist treatment service for women affect these relationships between client characteristics and treatment drop-out?

7.1.2 Study Method

The one hundred and sixty women already enrolled in the study who had stayed more than five days in treatment (COMP) were compared with 160 women who left treatment against advice less than five days after admission for drug and alcohol problems (DO). The mean length of stay was 2.33 days for the DO group and 21.2 days for the COMP group. Of these two groups, half from each attended either a specialist women's treatment service (Jarrah House) or one of two traditional mixed sex treatment services (Comparison Services).

Data on the characteristics of women who stayed less than 5 days in treatment were obtained from the agency's client records. Where the routine admission assessment instruments were not adequate, the researcher provided an additional questionnaire which was completed by all female admissions. Data were gathered using a structured interview.

7.1.3 Demographics

Age at the time of admission ranged from 17 to 66 years, the median age being 34 years in the COMP group and 34.5 years in the DO group. Women less than 25 years of age were significantly more likely to drop-out of treatment than were women greater than 25 years. This finding is consistent with reports across a variety of treatment modalities for both men and women.[3,6,7]

Approximately 53% of the women who dropped-out of treatment and 50% of those women that completed treatment were single, and 13% of the DO group and 11% of the COMP group were in de-facto relationships. Married women were less likely to complete treatment, with only eight percent of the COMP group compared to 15% of the DO group being married.

There is disagreement in the literature about the relationship between marital status and treatment drop-out, which may be related to the male bias in the literature. As women with substance dependence problems are more likely to have partners with similar problems than are men in treatment,[8,9] the significantly increased likelihood of married women dropping out of treatment may be related to a lack of spousal support for their admission. Family opposition to drug and alcohol treatment has been reported to be significantly higher for women than for men[10] and the lack of such support has been associated with treatment drop-out in a number of previous studies.[11,12]

7.1.4 Sexual Preference

Lesbian women were significantly much less likely to drop-out of treatment than were heterosexual or bisexual women. This is true across both types of treatment groups because lesbian women were much more likely to have completed treatment at Jarrah House than at the Comparison Services. This finding has not previously been reported in the literature. Many authors have suggested that although lesbian women have a higher incidence of drug and alcohol problems than heterosexual women, they are more difficult to recruit and retain in traditional drug and alcohol treatment services.[13-15] The reverse finding in this study is the result of a significantly increased recruitment of lesbian women to the specialist women's service. This interaction suggests that treatment drop-out of some groups of women with substance dependence problems can be reduced by appropriate matching of clients needs to treatment characteristics.

7.1.5 Children

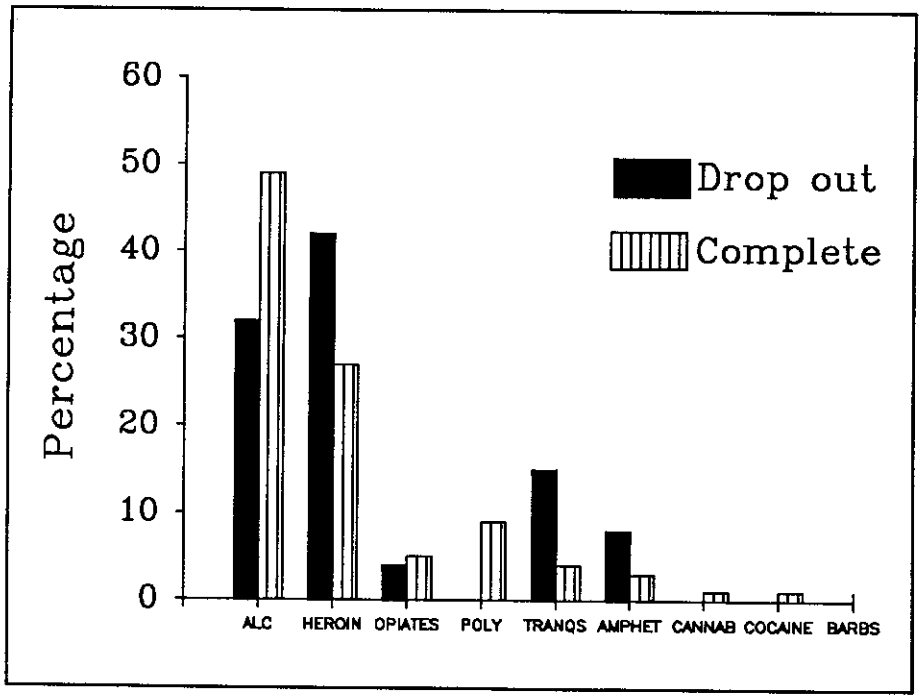
Approximately 45% of the women in the sample had dependent children and there was no significant difference in this proportion between the DO and COMP groups. However, women with dependent children who completed treatment were more likely to have attended Jarrah House than the Comparison Services. While there was no significant difference between the DO and the COMP groups in the percentage of women with dependent children, significantly more women with dependent children prematurely discharged themselves from traditional mixed-sex services, where their child-care needs and parenting concerns were not being met.

7.1.6 Employment

Women who were in paid employment were significantly much more likely to complete than to drop-out of treatment; 15% of the DO group and 53% of the COMP group reported being employed either part-time or full-time. The finding that 61% of the DO and 32% of the COMP had no employment skills is consistent with this finding. The finding that unemployment is the strongest predictor of treatment drop-out for women, replicates previous findings for both men and women.[11,16,17] Despite the emphasis on unemployment as a predictor of treatment drop-out in the research literature, the notion that the client should be at 'rock-bottom' with little left to lose before recovery is possible continues to be supported by the majority of the staff in the treatment agencies participating in this study.

7.1.7 Drug and Treatment History

Figure 7.1 **Drug of Choice by Treatment Drop-Out**



Heroin was cited as the problem drug by around 45% of the sample, and alcohol by about 41% (Figure 7.1). Women who reported heroin as their drug of choice were more likely to drop-out of treatment than were users of alcohol and/or other drugs, so too were women who cited amphetamines and

tranquillisers as their drug of choice. The finding that women who nominated heroin as their drug of choice were significantly more likely to drop-out of treatment has been reported in other studies.[7,18,19]

There was no significant difference in length of problematic drug use, with a median of 13 years of problematic drug use reported by women who dropped-out and 12 years by women who completed treatment. Women in their first substance dependence treatment were more likely to complete treatment than to drop-out, 16% of the DO group and 32% of the COMP group reported this to be their first drug and alcohol treatment. This finding does not support the 'clinical wisdom' that motivation to recover from addiction is positively correlated with the number of previous treatment attempts.[3] It may be that those who still have positive reinforcers in their lives to build on during the program that benefit most from an individual treatment experience rather than when a person is so far entrenched in a substance use lifestyle that they have nothing else to lose before they are prepared to abstain from alcohol and other drugs.

Women who had previously attended less than ten AA/NA meetings prior to admission were significantly more likely to drop-out of treatment than were women who had attended more than eighty AA/NA meetings. As all the treatment services in the study were primarily based on the disease model of addiction and 12-step programs, it is not surprising that women with a higher rate of AA/NA attendance prior to admission were more likely to complete treatment. This finding reflects the importance of a congruence of beliefs about the most effective treatment model between the treatment agency and the individual client.

The women who completed treatment most frequently cited concern about their loss of control over substance dependence (24%) as the primary reason for seeking this treatment, followed by concern about their health (19%), being 'sick of the lifestyle' (15%) and concern about the effect their substance dependence was having on their children (12%). Concern about the effect on their health of continued drug and alcohol use was reported most commonly by women who dropped-out of treatment (31%), followed by concern about their children (19%), family pressure to seek treatment (14%) and legal pressure to seek treatment (12%) as the primary reason for seeking treatment at this time.

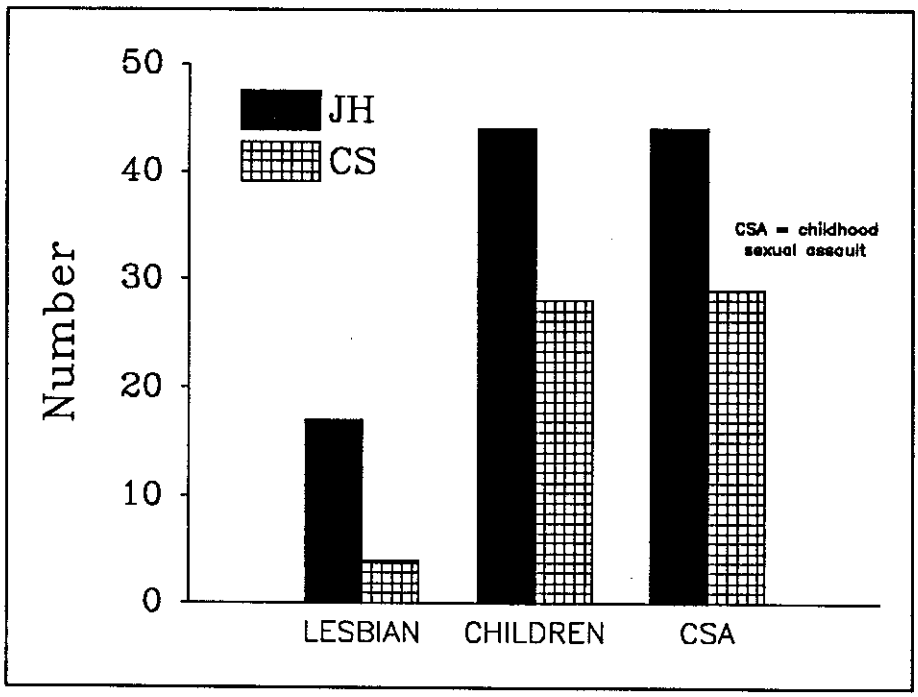
7.1.8 Life Experiences

Women who reported a history of sexual abuse in childhood were more likely to complete treatment than women with no such history, 36% of the DO group and

46% of the COMP group reported a history of sexual abuse in childhood (Figure 7.2). The women reporting a history of sexual assault in childhood who completed treatment were more likely to have attended the Jarrah House than the Comparison Services. In the case of sexual abuse in adulthood, around 36% of the DO group and 52% of the COMP group reported this experience. Women with a history of sexual assault in adulthood were more likely to complete treatment than those who did not report such a history.

Thirty four percent of the DO group and 28% of the COMP group reported having worked as prostitutes, but this difference was not statistically significant. The possibility of differential drop-out rates for women with a history of sexual abuse has not been previously examined. However, one study has suggested that women with a history of having worked as prostitutes are less likely to be retained in treatment.[18]

Figure 7.2 **Interaction Between Client Characteristics and Type of Treatment on Treatment Completion**



There has been a consistent finding across treatment type that women with a history of sexual assault in adulthood were more likely to complete treatment. This suggests that the traumatic effects of this experience may lead the woman to examine her increased vulnerability during intoxication. If the assault occurred in

the context of a sexual relationship, the woman may be more willing to seek and remain in the physical safety of a residential treatment setting.

The interaction between type of treatment and the incidence of drop-out is again observed for women who report sexual abuse in childhood (most commonly incest). Such women were significantly more likely to have completed treatment at Jarrah House than the Comparison Services. Women with a history of sexual assault in childhood appear to have an increased need for a physically and emotionally safe environment as their trust has been seriously violated in the past.[20] In addition to lesbian women and women with dependent children, the provision of a gender-sensitive treatment service may also reduce the incidence of treatment drop-out for women with a history of sexual assault in childhood.

7.1.9 Recommended Length of Stay

As the two comparison mixed-sex treatment programs were of varying lengths, they were compared to one another for the pattern of female client drop-out. There were no statistically significant differences in the characteristics of subjects from the 21 and 7 day traditional mixed-sex treatment services in either the DO or the COMP groups. There did not appear to be any significant differences in approach or expectation by subjects related to the recommended length of stay for the service, which is consistent with the literature that length of stay is not a reliable predictor of treatment outcome for residential services.[21]

7.1.10 Comment

The data from this study suggest that consideration of specific client characteristics, such as employment status, history of sexual assault (especially in adulthood), drug of choice, marital status and age, in addition to sympathy with the treatment philosophy of the agency (as measured by the AA/NA variable), may reduce drop-out for women seeking drug and alcohol treatment. For lesbian women and women with dependent children, the provision of specialist women's services appeared to reduce the likelihood of their prematurely discharging themselves from treatment.

7.2 Clinical Status at Discharge

The discharge interview was conducted on an average of two days prior to the woman leaving the treatment service. This interview was completed by 82% of

clients in the study (74% of the Jarrah House and 90% of the Comparison Services clients).

7.2.1 Length of Stay

The median length of stay was 28 days for women attending Jarrah House and 15 days for the Comparison Services, which was consistent with the recommended length of treatment in the respective services. The range of length of stay for Jarrah House clients was 5 to 50 days and 5 to 39 days for the clients of other centres.

7.2.2 Choice of Medication during Detoxification

The term "medicated detoxification" is used to define the use of psychoactive drugs (e.g., diazepam) to treat the symptoms of withdrawal from alcohol and other drugs. Clients of all treatment agencies in the study were much more likely to have an unmedicated than a medicated detoxification. While only Jarrah House claimed to offer clients the choice of a medicated detoxification, there was no significant difference in the percentage of women prescribed medication during their admission (19% of Jarrah House and 20% of Comparison Services clients).

7.2.3 Sex of Primary Therapist

None of the treatment services in the study provided continuity of therapist contact for clients. When clients were admitted, the staff member who assessed and oriented them to the service acted as their primary therapist. Jarrah House clients were more likely than those at the other centres to have frequent individual counselling with their primary therapist. Women attending the Comparison Services' were as likely to have a male as a female therapist.

7.2.4 Specialist Women's Services

Of the women in the study attending the traditional mixed-sex services who had dependent children, 62% said that they would have stayed in treatment longer had childcare been available. Comparison Services clients were also asked if they would have preferred to be in a women-only agency. It is not surprising that 59% said no, as they had just completed treatment in a mixed-sex service.

7.2.5 Reason for Discharge

The majority of subjects in both groups left treatment because they had completed the program (51% of Jarrah House clients and 89% of Comparison Services clients). Other reasons cited by a small number of clients included 'to be with their partner', 'to care for children', 'take care of business' and for 1.3% of both services - 'that the program was inappropriate for their needs'.

Four percent of Jarrah House clients left saying they could not cope with the program (none of the Comparison Services mentioned this concern). Women attending Jarrah House (12%) were significantly more likely to have been involuntarily discharged from treatment for disciplinary reasons than were subjects attending the Comparison Services (1%) The vast majority of reasons for disciplinary discharge from Jarrah House were related to staff assessment of the clients' attitude and motivation rather than rule infraction. Clients of Jarrah House were less likely to be anxious about discharge (39% Jarrah House and 53% Comparison Services) but were also less likely to be pleased about leaving (14% Jarrah House and 30% Comparison Services).

7.2.6 Referral Practices

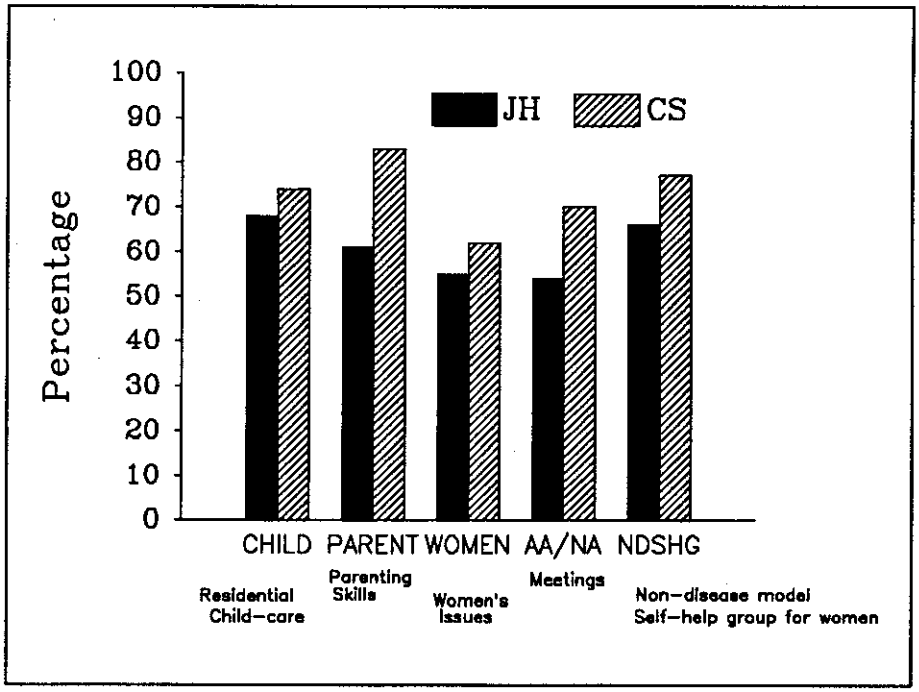
There were no significant differences in the types of referrals offered after treatment between the two types of treatment. Forty percent of Jarrah House and 58% of Comparison Services clients left to go to their own care. Ten percent of both groups went to residential rehabilitation programs. While eight percent of both groups went to women's half-way house programs, 9% of Comparison Services but only 3% of Jarrah House went on to mixed-sex half-way house facilities. Less than five percent of all clients were referred to out-patient counselling post-discharge.

7.2.7 Rating of Treatment Components

The subjects were asked to rate the usefulness of various treatment components on a 6-point scale ranging from 'not at all useful' to 'very useful'. Therefore, as Jarrah House offered gender-specific components that the Comparison Services did not, on a number of questions the Jarrah House subjects were rating their treatment experience, but the Comparison Services subjects were rating the perceived usefulness of such an option should it be available. The vast majority of subjects at Jarrah House (68%) rated residential childcare as very useful, and 74% of subjects at the Comparison Services agreed that residential childcare, if offered,

would have been useful. Similarly, 61% of subjects at Jarrah House rated parenting skills training as very useful and 83% of Comparison Services reported that they would have found such training very useful. Fifty five percent of subjects at Jarrah House rated discussion of women's issues (sexuality, relationships, health) as very useful, and 62% of the Comparison Services subjects agreed that discussion of such issues would have been very useful.

Figure 7.3 **Percentage of Clients Rating Treatment Components as 'Very Useful' by Type of Treatment**



Skills training such as social and survival skills and assertiveness training were much more strongly endorsed as very useful by Jarrah House clients (58% and 55%) than by Comparison Services clients (29% and 19%).

The majority of Jarrah House clients (66%) rated individual counselling as very useful. Fifty-three percent of Comparison Services clients felt that individual counselling was very useful. Although none of the services offered family therapy, 33% of Jarrah House and 19% of Comparison Services clients thought that it would be very useful for their recovery.

When asked to rate the utility of 12-Step meetings, 55% of Jarrah House and 71% of Comparison Services subjects rated them as very useful. Sixty six percent of Jarrah House and 77% of Comparison Services subjects indicated that they

thought a self-help group for women that was not based on the disease model of addiction would be useful for their recovery. Of the Wisteria House clients who attended clergy group, only 14% of them found it very useful and of all other subjects in the study only around 10% felt it would be at all useful in their treatment.

The rating of medical and health care as very useful differed between the Jarrah House (49%) and the Comparison Services (18%). This may reflect the disparate quality of health care offered by the services. Jarrah House had a group of caring, proactive female general practitioners attending the clients regularly, whereas, the traditional services, did not emphasise primary or secondary general health care despite being attached to hospitals.

7.2.8 Changes in Depression and Self-Esteem

Both groups demonstrated a significant reduction in their level of depression at discharge, but Jarrah House subjects had a significantly greater reduction in depression than Comparison Services clients. Similarly, both groups demonstrated a significant improvement in self-esteem at discharge with Jarrah House subjects showing significantly greater improvement in self-esteem than Comparison Services subjects.

7.2.9 Client Satisfaction

The general measure used in the study was the Attkisson Client Satisfaction Questionnaire. This questionnaire addresses issues such as the attractiveness of the physical environment, the competence of the staff, whether the client's needs had been met, whether their rights had been respected, and if they would recommend the service to others. There were no significant differences between the mean scores of the two types of treatment. The disaffection of a small group of Jarrah House clients, who had confrontational therapists, caused the client satisfaction scores for that service to have a larger variability and, therefore, a reduced mean score. The range of scores for the Jarrah House was 28-72 and for the Comparison Services 42-72, and the difference in variability for the two types of treatment was significant.

7.2.10 Comment

In summary, while there were no significant differences in the rates of drop-out for the two types of treatment, there were differences in the pattern of client drop-

out. Treatment in a specialist women's service made it significantly more likely that women with dependent children, lesbian women and women with a history of sexual abuse in childhood would be retained in treatment compared to traditional mixed-sex services. Female clients endorsed the options of women-only environment, residential childcare, parenting skills classes, self-help groups (particularly non-disease model groups), discussion of women's issues, attention to health and medical needs and individual counselling. There was evidence to suggest that, on average, clients of the women's service were more satisfied with some aspects of their treatment experience than were the clients of the other services, but this may have been masked by greater polarisation of scores among Jarrah House clients.

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CHAPTER 8 Outcome Six Months Following Treatment

8.0 Introduction

The most challenging aspect of this study was locating and interviewing the clients six months after admission to treatment. The women in the sample had moved a median of six times in the six months preceding the current admission and forty five percent of the sample were of no fixed address. Despite these difficulties, sixty one percent of the total sample were followed up at an average of 27 weeks after admission. Some outcome information was obtained on 90% of the women who took part in the study.

8.1 Changes in Clients Substance Use[a]

Overall, there was a significant reduction in consumption of heroin and alcohol at six-month follow-up, a significant reduction in the number of drug categories that subjects used between admission and six-month follow-up, and a significant improvement in health over the six-month period.

Among the subjects who were interviewed, approximately two-thirds in both treatment groups had used drugs or alcohol in the six months following discharge (Table 8.1). The first substance use occurred after a mean of 1.2 weeks for women attending Jarrah House and after 1.0 weeks for those attending the Comparison Services. If subjects who were not located at follow-up are considered to be treatment failures, the abstinence rates were 24% for the Jarrah House clients and 19% for the Comparison Services.

Around 50% of the women interviewed at follow-up believed they had control over their drug and alcohol use. Among women who were drinking 60 grams or more of alcohol per day on admission, 22% of Comparison Services subjects and 13% of the Jarrah House subjects were now drinking on average less than 20g grams per day of alcohol (this figure does not include subjects who were abstinent) at six-month follow-up.

The results of this study are consistent with the research indicating that a percentage of alcohol-dependent subjects in treatment outcome research will be practising controlled drinking. Such accounts are common in the literature.[1] A number of studies have concluded that females are more likely than males to successfully practise controlled drinking.[2,3] Given this evidence it would appear that offering the choice of a goal of controlled drinking combined with an

[a] *Please see Appendix F for details of statistical analyses*

appropriate treatment regime may be particularly relevant for a gender-sensitive treatment service.

Table 8.1 Treatment Outcome of Subjects Interviewed at 6-Month Follow-Up by Type of Treatment

	JH (n=52)	CS (n=45)
Used alcohol or other drugs (%)	63	64
'Risky' substance use (%)	27	35
Intervening Detox (%)	15	20
Intervening drug-related conviction (%)	8	13
AA/NA attendance (%)	67	62
Perceived control over use (%)	56	49

† None of these differences reached statistical significance

8.2 Other Measures Related to Substance Use

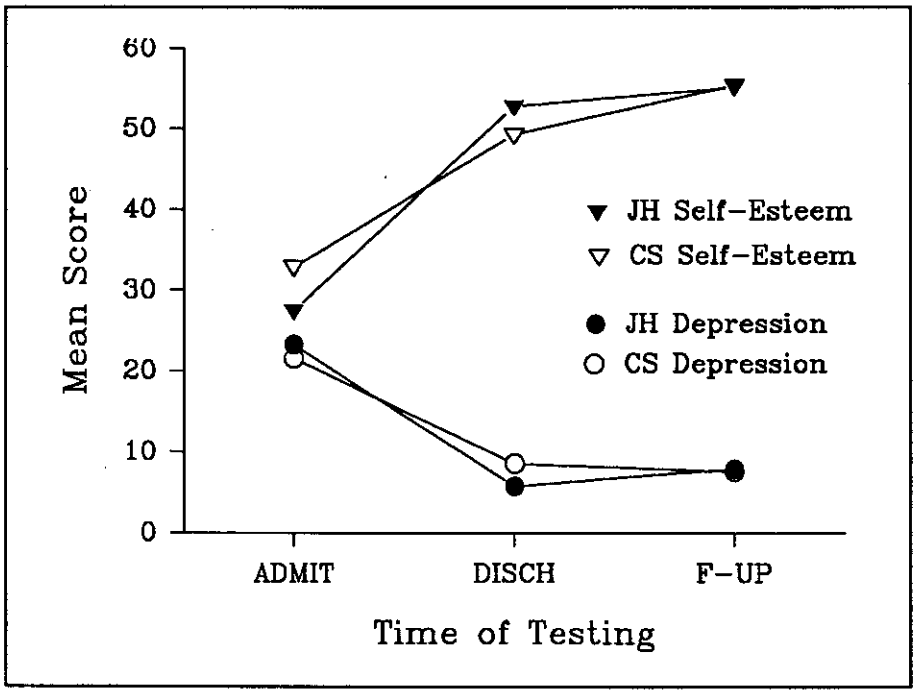
Commission of a drug-related criminal act was reported by seven percent of Jarrah House and 13% of the Comparison Services subjects in the previous six months. Fifteen percent of the Jarrah House and 20% of the Comparison Services subjects required a further detoxification in the six months following discharge. Of the subjects located at follow-up, 67% of Jarrah House and 62% of Comparison Services subjects were attending AA/NA meetings at least once a week. There was no significant difference between the two types of treatment on any of these outcomes, but there was a consistent small difference in favour of Jarrah House on most of the outcomes. It is interesting to note that despite the low rates of abstinence, the majority of clients were attending 12-step meetings regularly while believing that they had control over their substance use. This apparently contradictory behaviour may be explained by the important social support provided by 'self-help' groups or as they have been more appropriately described

by Room (1990),[4] 'mutual-help' groups. It appears that many members of such groups attend for the social support without necessarily subscribing to the disease model and abstinence goal that are part of its philosophy. These mutual support aspects of 12-step meetings appear to attract some women to such groups even though they may find aspects of the program that emphasise insanity and the impossibility of control over their substance use and lives in general, disturbing.[5]

8.3 Changes in Psycho-Social Measures

On average, there were significant improvements in depression and self-esteem for both treatment groups compared to the admission scores. There were no changes in depression or self-esteem scores between discharge and follow-up, nor were there any differences between groups in these scores (Figure 8.1).

Figure 8.1 **Mean Depression and Self-Esteem Scores by Group & Time of Testing**



The apparently greater improvement in depression and self-esteem score for Jarrah House clients at discharge had disappeared by the six months follow-up. One explanation for this is that the apparent short-term beneficial effect of the specialist women's service may have been as a result of the longer time in treatment for Jarrah House clients compared to the clients of the mixed-sex Comparison Services.

When compared to assessment on admission there was a significant improvement in the subject's social support network in both treatment groups. Women attending Jarrah House and the Comparison Services also demonstrated a significant improvement in maternal satisfaction over the six month period. There was no significant change in employment status from admission to follow-up. There were no significant differences between the two types of treatment on any of these variables.

8.4 Predictors of Substance Use at Follow-Up

The only significant predictor of drug use six months following treatment was a previous history of admission to a psychiatric hospital. Women who had ever been admitted to a psychiatric hospital were more likely to have used alcohol or other drugs at follow-up than were women with no such history. This finding is consistent with other studies, which have found that psychiatric co-morbidity is a predictor of poor treatment outcome.[6,7]

Figure 8.2 Percentage of Clients with Children, in Stable Relationships or Employed Who Were Engaged in 'Risky Behaviour' at 6-Month Follow-Up by Type of Treatment

The failure to find a relationship between treatment outcome and traditional predictors of treatment outcome as age,[3] level of dependence,[8] and employment[3] may have been due to low statistical power as a consequence of the small sample size in this study.

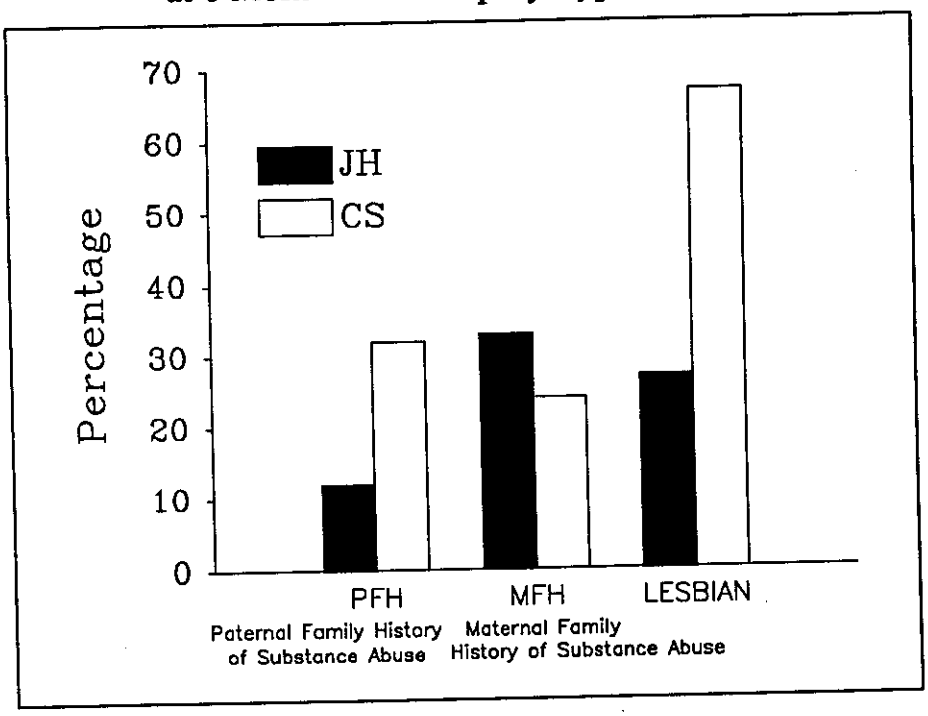
Women whose fathers had a history of substance abuse problems were more likely to have used alcohol or other drugs six months after treatment than were women with no such history. While this result was not statistically significant, the lower limit of the confidence interval narrowly includes the null value, and it would be unwise to conclude that there was no difference (Appendix F). The overall finding that women with a maternal history of substance dependence did more poorly than women with a history of paternal substance dependence at 6-month follow-up has previously been cited in the literature.[3,9] However, the reason for a differential effect in favour of the specialist women's service among women with a paternal family history of substance dependence as found in this study is not readily apparent.

8.5 Relationships Between Client Characteristics & 'Risky' Substance Use

Although there were no statistically significant relationships between type of treatment and substance use at follow-up, a few results are deserving of further research. As complete abstinence was only achieved by around 35% of the subjects located at follow-up, the relationships between key variables and treatment outcome have been analysed on the basis of a harm minimisation model. In this analysis 'risky' substance use was defined as any injecting drug use, average alcohol consumption of more than 20 grams per day, any cannabis or psycho-stimulant use, and any non-prescription analgesic or tranquilliser consumption of more than 2 tablets per day over a period of the month prior to interview.

Certain client characteristics seemed to predict a lower rate of risky substance use behaviour amongst women who attended the specialist women's service. Women with a paternal history of substance use, lesbian women, women who had ever worked as prostitutes, and women with a history of sexual assault in adult life who attended Jarrah House were less likely to engage in risky drug use at follow-up than were women with the same histories who attended the Comparison Services (Figures 8.2,8.3 and 8.4).

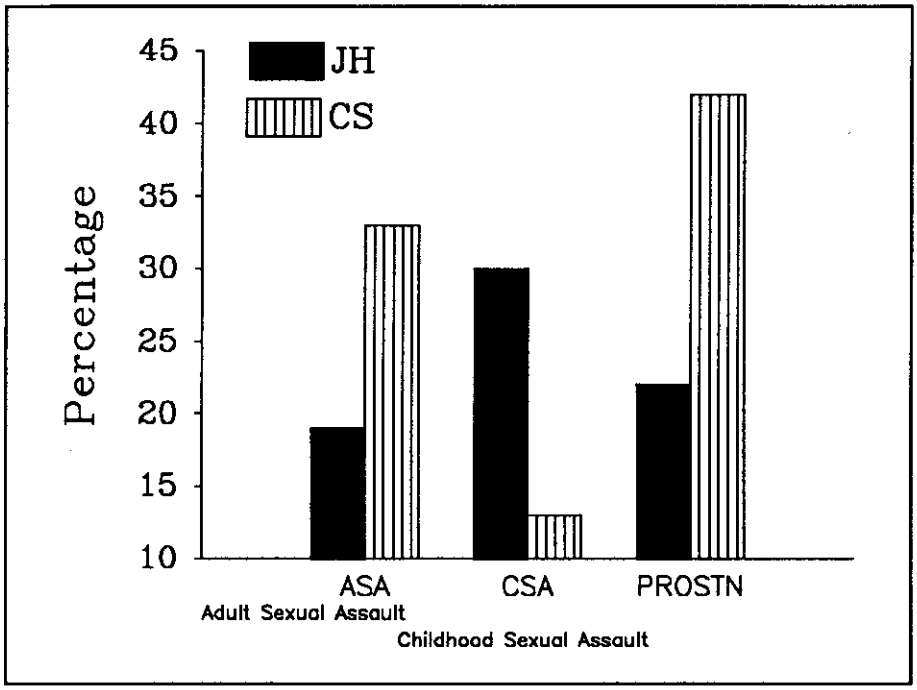
Figure 8.3 Percentage of Clients with a History of Sexual Assault or Sex Work Who Were Engaged in 'Risky Behaviour' at 6-Month Follow-Up by Type of Treatment



By contrast, women with a history of sexual abuse in childhood who attended Jarrah House were *more* likely to have engaged in 'risky' substance use in the six months following treatment than were women with such a history who attended the Comparison Services. (See Appendix F for details of the statistical analyses.) This finding, which was unexpected, is potentially very important considering the prevalence of childhood sexual abuse among this cohort.

At the time of the study Jarrah House had recently changed its policy from one that advised clients *not* to address issues of childhood sexual assault until they had achieved six months abstinence, to one that emphasized the importance of discovering and resolving all aspects of such abuse during the treatment program. This change had a number of consequences. First, staff who were not professionally trained in the counselling of sexual assault survivors attempted to do so and some of these staff applied a model that involved coercing the client to dwell on painful and often overwhelming emotions.[10] Second, there was a lack of systematic on-going therapy provided to the clients to deal with childhood sexual assault issues. This combination of factors may have contributed to the increased likelihood of relapse in this group attending Jarrah House.

Figure 8.4 Percentage of Clients with Positive Family History of Substance Use and Lesbian Clients Who Were Engaged in 'Risky Behaviour' at 6-Month Follow-Up by Type of Treatment



The seemingly negative impact of this form of counselling does not imply that the issue of sexual assault should not be raised in an alcohol and drug treatment setting. It may be, for example, that acknowledging a woman's history of sexual assault and making available professional, empathic therapy when the woman is "ready", would have reduced the relapse rates. This is clearly an important research question with obvious clinical relevance.

8.6 Sex of Therapist

Women attending the traditional mixed-sex programs who had a female primary therapist were more likely to be located at follow-up than were Comparison Services client who had a male therapist. In addition, Comparison Services subjects with a male primary therapist were more likely to have used alcohol or other drugs during the six months following treatment than were those with a female therapist. Although neither of these differences were statistically significant, they are worthy of further exploration. The finding that women at the Comparison Services who had a female primary therapist were less likely to be engaging in 'risky' substance use six months following treatment than were

women with a male therapist is supported in the literature.[11,12] This suggests that in traditional mixed-sex services, the matching of female clients to female therapists may improve the chance of a positive outcome for those clients.

8.7 Additional Information for Subjects Not Interviewed at Follow-Up

Information was sought by the researcher (JC), on the sixty one subjects who were not able to be located or who refused to be interviewed at follow-up. The sources of information were the admission records of the participating agencies and treatment agency staff members who attended 12-step meetings and had contact with subjects at these events. Subjects were classed as doing 'well' if they were employed and/or not using alcohol or drugs in such as way as to lead to an obvious problem in their lives at that time. Subjects were classified as doing 'badly' if they were known to be using alcohol and other drugs in a problematic way, or if subsequent admission records revealed that their substance use was unchanged, or worse than that on admission to the agency. Sixty-eight percent of Jarrah House subjects and 54% of Comparison Services subjects who were not interviewed, were considered to be doing 'badly' at 6 months after treatment. In all, some data were available for 90% of subjects. This information did not substantially change the treatment outcome findings for either treatment group.

8.8 Collateral Verification of Subject's Self-Report

The level of agreement between the subject's report and that of the collateral was assessed by Cohen's Kappa (between .40 and .75 is considered to represent fair to good agreement beyond chance[13]). As Table 8.2 shows, by this standard, alcohol, amphetamines, minor tranquillisers, tobacco and number of accommodation moves exhibited reasonably good agreement between the subject's and the collateral's account of the subject's behaviour in the six months following treatment.

While on initial inspection these relationships were not strongly supportive of self-report, further exploration suggested that in most cases of disagreement, the subject was reporting higher rates of drug consumption or criminal activity than was the collateral. The more correct interpretation of the collateral data collection in this study was that significant others providing collateral data often seriously *under*-estimated the subject's drug consumption and other behaviours related to

treatment outcome. This finding is consistent with other accounts of the reliability of self-report by substance using populations.[14-16]

Table 8.2 Relationship Between Self-Report and Collateral Data on Key Outcome Variables at 6-Month Follow-Up

Variable	Cohen Kappa	Proportion of Self/Collateral Underestimate
Heroin use	.31	.28*
Other opiates use	.31	.28*
Alcohol use	.61	.45*
Cannabis use	.30	.58
Amphetamine use	.67	.67
Cocaine use	-.04	.67
Minor tranquillisers	.54	.50
Tobacco	.70	.14*
Employment	.54	.54
No. of moves	.58	.48*
Criminal activity	.22	.10*

* where the proportion is <.50 the subject has reported a higher incidence of either drug use, accommodation moves or criminal activity than their collateral

8.9 Comment

The failure of this study to demonstrate a statistically significant difference in outcome between the specialist women's and traditional mixed-sex services requires careful consideration as, for a variety of reasons, it would be unwise to infer that this means that there is *no* benefit of specialist women's services. The most obvious of these reasons, as discussed in the data analysis section of chapter 2, is that this study had low statistical power to detect all but the largest of differences between the two types of treatment.

Compared to the Dahlgren & Willander study,[17] the women in this cohort were younger, severely dependent on a range of psychoactive substances, had a median of five treatment attempts, and about half were unemployed. The nature of the specialist women's program was also quite different. In this study Jarrah House was a short-term residential service with a number of non-professional staff in comparison to the long-term out-patient program using all professional staff in the Swedish Study. These large differences in client and program characteristics may explain the differences in outcome of these two studies of specialist women's

services. In addition, since the women in this study had severe and long-standing substance dependence problems with serious psycho-social and economic ramifications it was less likely that there would be major and enduring changes in alcohol and other drug use over six months from a single treatment episode.

A further problem with the interpretation of this research is that there were minimal differences in the theoretical approaches employed by the staff of Jarrah House and Comparison Services. The vast majority of staff at the Jarrah House and all of the staff at the Comparison Services employed the disease model and 12-step programs as the theoretical basis of the treatment. This is consistent with the average abstinence rate of around 21% at six months follow-up in this study, which is similar to those found for Alcoholics Anonymous members in other studies.[18]

It is also important to note that there were some differences between the clientele of the Jarrah House and the Comparison Services which suggested that Jarrah House was attracting and retaining a clientele with more serious and complex problems.[19] Lesbian women, women with dependent children, women sexually abused in childhood and/or with a maternal history of substance dependence were significantly more likely to attend Jarrah House than the Comparison Services.

This combination of women with extreme substance dependence and psycho-social problems, minimal differences in theoretical approach, and differences in clientele profile implies that at most there was a moderate difference between Jarrah House and Comparison Services which the sample size had a small chance of detecting. However, the results of this study do indicate that there was not a large difference in favour of the type of Jarrah House investigated.

The trend for lesbian women, women with a history of prostitution, and those who had experienced more recent sexual assault attending Jarrah House to have a superior outcome requires replication with substantially larger sample sizes. The severity of problems demonstrated in this cohort, and the failure of this particular specialist women's service to offer a substantially different theoretical model of treatment, suggest that replication in a multi-centre trial employing a feminist, relapse prevention model and choice of treatment goal[19,20] would clarify the role gender-sensitive services have to play in the treatment of chemical dependence.

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CHAPTER 9 Implications for Practice, Policy & Research

9.0 Introduction

In this chapter we discuss the implications of the evaluation for clinical practice and treatment policy for women with drug and alcohol problems. First we present a summary of the findings, followed by a discussion of the implications for specialist women's services like those provided at Jarrah House. Second, we also make some suggestions about the ways in which the treatment of women in traditional mixed-sex drug and alcohol services could be improved, since it is unlikely that all women with drug and alcohol problems can be treated in specialist services. Finally, a brief discussion is provided of how the conduct of outcome evaluations of specialist women's services could be improved.

9.1 Summary of Findings

This study compared the characteristics of eighty women attending Jarrah House with those of eighty women attending two traditional mixed-sex treatment agencies. Women attending the specialist women's service were significantly more likely than those attending traditional mixed-sex programs to have dependent children, to be lesbian, to have a maternal history for drug or alcohol problems and to have suffered sexual abuse in childhood. In addition, it was shown that attendance at a specialist women's service reduced the incidence of treatment drop-out among lesbian women, women with a history of sexual assault in childhood, and those with dependent children. Six months following treatment, there were no significant differences in any measure of treatment outcome between the two treatment groups, although there were trends to suggest an improved outcome for clients of the specialist women's service.

9.2 Implications for Jarrah House

To what extent where the main objectives of the Jarrah House program met? To be more specific: (1) to what extent was Jarrah House successful in attracting a different clientele from traditional mixed sex services? Did Jarrah House attract women earlier in their problem history, and did it succeed in attracting special groups of women who have been under-represented in traditional treatment, such as lesbian women and women who had a history of sexual abuse as a child or an adult?; (2) to what extent did Jarrah House better meet the needs of women with

drug and alcohol problems by providing child-care and a wide range of treatment choices?

9.2.1 Attracting Clients into Treatment

Jarrah House had mixed success in attracting women into treatment. It failed to encourage women to seek early intervention for alcohol and other drugs/dependence problems as there were no differences between the clients of Jarrah House and the traditional mixed-sex treatment services in the length of problematic substance use prior to treatment. Jarrah House clients had experienced problems for a mean of five and a half years (a median of 11 years) and the clients of the other services for a mean of 5.8 years (a median of 9.5 years). Nor were there were any differences between the two groups in severity of dependence on psychoactive drugs.

Jarrah House was more successful in attracting women with special problems that are unlikely to be addressed in traditional mixed-sex programs. These included lesbian women, women with dependent children or a history of loss of custody of their children, women whose own mothers who had a problem with alcohol or other drugs, and women who have experienced sexual assault in childhood. It was also successful in its aim of providing a statewide service to drug and alcohol dependent women. It succeeded in attracting women from non-metropolitan New South Wales, other Australian states and New Zealand even though its capacity to service all of New South Wales was limited by its ability to accommodate only 13 women and eight children at one time.

9.2.2 Treatment Provision

A major aim of the women who established Jarrah House was to meet the diverse needs of drug and alcohol dependent women by providing a broad range of treatment options. This was an aim which the program most conspicuously failed to meet. Both the six-month observational report in 1987 and this study have found that the Jarrah House program is overwhelmingly based on the disease model and the 12-step approach to treatment. While efforts have been made by the management committee to respond to these recurring criticisms over a period of 5 years, they have not been effectively supported in practice.

The comments in a letter of resignation from a senior drug and alcohol counsellor at Jarrah House dated 20th February, 1990 crystallised the difficulties

faced by professionals who did not share a wholehearted commitment to the disease model:

> "At the time of my interview, I was not informed that I would be the only one who did not support the disease concept. Since working at Jarrah I have found it to be an environment that does not encourage women to make informed decisions and realise that they have choices. In my work I encourage women to deal with issues as they arise. This is not the case with other staff members who appear to focus on the fact that 'you have a disease, and the only way you will stay alive is to accept this and adjust to the fact that you can't do anything about it'. ... Jarrah House is funded on the understanding that it offers a range of alternative approaches to drug and alcohol use. Whilst I worked at Jarrah the range appeared to be the Disease Model plus me."

While the Jarrah House program did not offer any alternative to the disease model of addiction, there were a number of natural therapies available for relief of withdrawal symptoms and relaxation. These included massage, fragrant oil baths, and meditation. A clinical supervisor has attempted to introduce an idiosyncratic therapy which attempts to combine feminist, psychoanalytic and 12-step philosophies to the Jarrah House staff. As there is no empirical or theoretical basis to support such an approach, we cannot support its use in a short-term, residential program that attracts severely dependent and socio-economically disadvantaged clients.

Jarrah House also had not met its aim of reducing the rate of drop-out among women seeking alcohol and other drug treatment. Over the course of the study, 36% of Jarrah House clients left treatment within seven days of admission compared with 28-35% of the clients at the Comparison Services. This inability of Jarrah House to reduce the treatment drop-out rate may be related to its six week recommended length of program. If a woman found the prospect of achieving and sustaining abstinence daunting she may be more likely to drop-out of a longer than a shorter program.

Jarrah House had more success in meeting some of its operational objectives. It was, for example, able to provide a 24-hour service to meet the detoxification needs of alcohol and other drug dependent women (and their children), although assessments and admissions were only conducted during business hours seven days a week. It provided competent professionals to supervise detoxification in a caring environment in which the clients were safe from sexual and physical

harassment, and sheltered from external pressures of family and other responsibilities. It also provided a short-term residential rehabilitation program for women and their children, following detoxification, of which the majority of clients took advantage.

Jarrah House was better able to provide both individual and group therapy according to the specific needs of each woman than were the traditional mixed-sex services. It offered a full program of group and individual therapy, and its emphasis on individual therapy was appreciated by clients. A strong preference for individual therapy was expressed by many of the women who attended the traditional services. The way in which the two modes of therapy were tailored to meet the individual needs of the women varied enormously with the particular therapist. While more professional and experienced counsellors were able to provide alternative models of treatment for their clients, some therapists only attempted to interpret the clients' reality according to the model of substance use to which they subscribed.

Jarrah House was less successful in achieving its aim of providing accurate community service information (legal, health and welfare) to both resident and non-resident women. The part-time welfare worker resigned from Jarrah House in the early stages of the study. Thereafter, the dissemination of community service information was sporadic and only a minor part of the service's activities. The lack of a welfare worker also meant that another aim of the program, the assessment of the needs of the clients' families for information and referral, was not met.

Jarrah House was able to provide some follow-up support services, such as ongoing counselling, and assistance with housing. The co-ordinator and some staff provided counselling after discharge on an ad-hoc basis. On occasions staff went to extraordinary lengths to assist ex-clients in dealing with their substance use and life problems. An ex-clients' group and a therapist-led out-client group were also available, but often did not attract a sufficient number of clients to be worth providing.

The program also provided appropriate care and referral of its clients' dependent children. The children were assessed by the child-care workers and the visiting medical officer, and were provided with appropriate referral to other agencies as required. The degree of liaison with health and other welfare services was variable. Staff members generally resented the amount of time spent on taking clients to the local Commonwealth Employment Service and other social

welfare agencies. However, Jarrah House liaised with other specialist agencies and referred when appropriate.

Finally, the Jarrah House program failed in its objective of monitoring closely the extent to which the objectives of the centre were being met. The Jarrah House management committee required no evaluation of either the process or outcome of the program by the co-ordinator. The only information gathered was that required by the funding body, which was not reviewed in a systematic way for monitoring or self-appraisal purposes by the staff or management.

9.3 Recommendations for the Jarrah House Program

As a result of the evaluation, guidelines were drafted to improve the treatment of women with substance use problems. As there are still a great number of questions to be answered about the treatment of women with alcohol and other drug problems these guidelines are not prescriptive. Rather, they are based on the existing empirical research literature, "clinical wisdom", observations of the treatment process in specialist and traditional mixed-sex settings, candid discussions with women clients, and the treatment outcome findings of this study.

9.3.1 Management Committee

The foundation members of the Women's Alcohol and Drug Advisory Centre are an inspirational group of women. They identified a need, organised, agitated and succeeded in realising their dream of a women-centred treatment service despite potentially divisive philosophical differences within the group. However, their hope of being able to turn the day-to-day operation of the service over to a co-ordinator has not been achieved for a variety of reasons.

The primary difficulty was that the WADAC committee was composed of extremely busy professional women, who frequently did not have the time and/or energy to ensure that their decisions were implemented. The committee passed a number of resolutions to address criticisms raised in evaluation reports and the resignation letters of staff members but there was no mechanism for translating their resolutions into action. As the committee members were all voluntary, it may be necessary to have a paid member with the responsibility of overseeing the implementation of the committee's resolutions by liaising with the co-ordinator and other staff members to facilitate the required action.

9.3.2 Physical Location and Facilities

A number of women in the study complained about the physical location of the building with its excessive traffic noise, bright street lights outside their bedroom windows, and the smallness of the garden and children's play area. Almost all of the staff complained about the lack of private counselling areas. The lack of private office space for the co-ordinator and Drug and Alcohol counsellor mitigates against recruiting suitably qualified professionals.

Relocation to a more appropriate building would provide:

- enable child-care facilities to be expanded. As Jarrah House is only able to accommodate eight children, it is severely limited in the number of women with dependent children it can admit, particularly if they have more than one child. The expansion of child-care facilities would also enable Jarrah House to offer an out-patient service in addition to, or instead of, a residential program. It may be possible to share child-care facilities with an appropriate health care service in the area to reduce cost.

- enable Jarrah House to offer out-patient services to clients. This would facilitate the development of a more eclectic and empowerment-oriented service. As the disease model is seen by many staff to be incompatible with any other model or goal of treatment in a residential setting, an out-patient service may be more appropriate for the trialing of new therapies at the service.

- provide a more relaxing environment for clients, away from road noise and with access to open spaces and appropriate play areas for their children.

- Provide staff members with appropriate and private counselling areas.

- provide for the co-ordinator office space in which to conduct confidential discussions, provide supervision, and to reflect on the functioning of the service. Few professionals would accept a senior position without the necessary privacy to deal with clients, staff members or visitors.

9.3.3 Staff Selection and Supervision

The selection of staff has been a central and continuing problem for Jarrah House. At the time the service opened in 1987, there were very few staff (particularly registered nurses) who had trained in any model other than the disease model. While the treatment approach described in the AA Big Book is not a confrontational one, the American Minnesota approach has popularised the practice of confrontational counselling. In recent years, alcohol and other drug treatment has included goals of harm-reduction and controlled-drinking, and treatment models have encompassed cognitive-behavioural techniques such as motivational interviewing and relapse prevention. Despite these developments, and the continuing criticisms of the service for not providing other treatment models, Jarrah House continues to provide only the 12-step approach to treatment.

The primary reasons for this are the two-tier system of staff selection and the lack of professional support for new therapists. The co-ordinator and the drug and alcohol counsellor were employed on the basis of professional qualifications and experience by a panel of three committee members. However, other staff members were employed on the basis of an informal interview with the co-ordinator which meant that the management committee have had no influence over and no knowledge of the staff members' background or experience.

All but short-term casual staff should be selected through a system of formal written application and interview process. As the salaries of registered nurses are now at least that of other similar professionals, thought should be given to the expansion of the professional staff base to include social workers, psychologists and welfare workers. If a mix of recovered and professional staff members is considered appropriate, all untrained staff members should have clinical supervision from more experienced staff members.

At least monthly attendance at clinical supervision and staff meetings should be a condition of employment. If staff are on a rostered day off they must attend (within reason and with time in lieu to be granted). The refusal of staff members to attend clinical supervision and staff meetings contributed to the lack of cohesion among the staff, a problem which was compounded by the employment of a large proportion of part-time staff. Both factors have inhibited the evolution of a demonstration treatment program.

The lack of support for new therapists who were specifically employed to provide an alternative to the disease model has been discussed in relation to the functioning of the WADAC committee. It is imperative that such professionals be

afforded an appropriate status, that support is provided for change, and that the perspectives of all staff members are respected.

9.3.4 Client Base

The emphasis on the disease model at Jarrah House and other services has meant that a large number of potential clients may have been excluded. With the public health emphasis on harm reduction there are increasing numbers of women in methadone maintenance treatment in Australia. A specialist women's service with child-care facilities should be available to such women to detoxify on an out-client basis and to enable women to selectively detoxify from other psychoactive drugs while continuing on methadone.

The insistence upon a goal of abstinence meant that women who were not physically dependent on alcohol were not able to explore moderation as a goal. As an aim of Jarrah House is to promote early intervention with substance use problems, it would be appropriate to provide such services to clients on an out-client basis.

9.3.5 Treatment Goal

The provision of a choice of treatment goal by Jarrah House clients has been discussed in a number of the preceding guidelines. As this and other research demonstrates, a proportion of women dependent on alcohol will successfully pursue a goal of moderation even when instructed that this is not appropriate or possible.

In selecting those women who may be encouraged to pursue a goal of moderation, it would be appropriate to screen all clients on the usual exclusion criteria for a goal of moderation. These criteria include lack of desire or social support to pursue moderation, physical dependence, health problems, and failed previous attempts at moderation of consumption. Those women who meet these criteria and who are keen to attempt controlled drinking should be provided with an opportunity to do so on an out-patient basis. Clients who are dependent on other drugs may wish to be taught the skills involved in controlled-drinking programs to prevent the development of subsequent alcohol-related problems.

9.3.6 Program Length

There was no relationship between length of stay and treatment outcome, irrespective of type of treatment, for those who stayed in treatment beyond five

days. The choice of six weeks as the recommended program length for Jarrah House was not empirically based. While in practice clients decide for themselves the appropriate length of stay, the cost-effectiveness of the service and clients access could be improved by a more thorough assessment of the clients' needs.

These assessments should evaluate the following:

- Does the client require a residential program? For example, does she require medically supervised in-client detoxification because of unsafe housing, the absence of a supportive family, or because she is unable to physically access the service?

- Attempts should be made to liaise with local safe accommodation to enable clients to attend the long-day out-patient program if the primary reason for offering residential care is the lack of appropriate accommodation.

- If the client does require residential treatment, liaison with welfare and housing services should be arranged as soon as appropriate.

- Clients should be frequently reviewed to see if they are suitable for discharge to intermittent or long-day out-client care, or for referral to other longer-care residential services such as therapeutic communities or half-way houses

9.3.7 Program Content

As Jarrah House is funded to offer its clients alternative models of treatment, it should provide treatment based on models other than the disease model. This could be done by incorporating an additional explanation of addiction, such as a social learning model, and allowing the client to decide which fits best with her understanding of her problems. An important feature of such models is a client-centred, non-confrontational approach to therapy. The empowerment of clients to deal with their concerns, rather than an emphasis on powerlessness and lack of control would be appropriate. Such techniques might include social skills training and relapse prevention. It is crucial that appropriately trained staff be available to implement such techniques.

Implications for Practice, Policy & Research

The ways in which problems such as sexual assault and psychiatric co-morbidity are managed requires clarification. The study found that women with a history of childhood sexual assault who attended Jarrah House were twice as likely to have relapsed to substance use six-months following treatment than those who attended the traditional mixed-sex services. The appropriate clinical management appears to include:

- Sensitive assessment of whether a history of sexual assault is present.

- If the client acknowledges that it is something she has experienced, and that it may be affecting her life, she may be asked if she would like to incorporate an exploration of its possible role in her substance use problems in her treatment.

- If she wishes to do so, the client should be referred to a therapist who is able to take on the long-term management of the client during her stay and after her discharge from the program.

Counsellors who do not have professional training in the management of sexual assault issues should not attempt to address such concerns. Clients should not be coerced into diary writing and prolonged descriptions of their experiences.

Clients with a history of chronic psychiatric problems, and who are considered stable enough for admission, should be referred to psychiatric services, if required. The few clients in the study with a chronic psychiatric condition commented that "they should not get involved in issues surrounding my psychiatric illness; they made things worse as it is not their area of expertise". It is tempting for drug and alcohol counsellors to interpret all their clients' difficulties as symptoms of their substance misuse, and to offer simplistic solutions to chronic and complex problems.

Jarrah House was the only longer term program that did not offer clients unsupervised lunchtime or week-end leave. The opportunity for clients to practise newly acquired skills and to have privacy to discuss issues with their friends and families while still in the supportive environment of the program would be useful.

9.3.8 Outreach, Liaison and Follow-Up

Improved outreach would be an appropriate part of an expanded service which provided out-patient care. This would be especially useful among the target groups of young women, women with dependent children, lesbian women, women with a history of sexual assault, and women who have worked in the sex industry. If Jarrah House continues to be the only residential detoxification program that offers child-care, then intra- and inter-state outreach may be appropriate.

This outreach effort would incorporate liaison with all appropriate cross-referral agencies such as sexual assault services, children's services, women's and general health clinics, community health centres, selected general practices, psychiatric services, and other specialist alcohol and other drug services.

As relationships develop with other agencies, it may be easier to arrange systematic follow-up. If an out-patient service develops, a number of follow-up groups may be possible. These could include job clubs, self-esteem groups, parenting skills, relaxation, assertiveness training and self-help groups for women that were not based on the disease model of addiction. The importance of attending to the general welfare, housing, educational and vocational needs of clients cannot be under-estimated.

9.3.9 Program Evaluation

Currently Jarrah House provides its funding body with the basic information on patient numbers and demographic characteristics that is required of all non-government alcohol and other drug treatment services. While evaluation was a condition of funding, the management committee and staff have relied on external evaluators to provide information on treatment process and outcome. While external and independent evaluation is extremely valuable, the program requires a more regular on-going monitoring of the treatment program. It is tempting for staff to dismiss the findings of a single evaluation as biased or unrepresentative in some way. It is preferable that staff and clients obtain systematic feedback on the treatment process and outcome in order to maximise the program's responsiveness to the changing needs of its constituency and to ensure that it is meeting its own aims and objectives.

9.4 Policy Recommendations for Specialist Services

The following brief comments relate to the policy implications for those who fund the establishment of any alcohol and other drug treatment service that proposes to provide a 'demonstration' service for the special treatment requirements of a particular sub-group.

The onus should be on the group requesting the funding of a service to offer an alternative model of treatment, and to demonstrate that a pool of suitable staff is available for recruitment. In addition, the initial training and skills development of staff in the non-government sector should be mandatory and funding should be contingent upon these two criteria. There should be sufficient budget allocation to employ suitably qualified senior staff to ensure the quality and integrity of the proposed program content.

The structure of the management committee should be such that it provides stability and the inclusion of a stipend to a nominated member to ensure that decisions are enacted as recommended.

Experience gained from the Jarrah House service indicates that it may be more appropriate to link the service into the area health service structure. This would free the management committee from the onerous task of day-to-day financial management enabling them to better supervise the content and quality of the treatment program. Such a funding structure would also enable the organisation to pay staff any award supplements and provide other infrastructure support.

9.5 Recommendations for Treatment in Traditional Mixed-Sex Programs

Many of the issues addressed in the guidelines for changes to the Jarrah House program may be implemented in a modified way in traditional mixed-sex services. The following are some recommendations for consideration.

9.5.1 Accommodation

Many of the women who attended the traditional mixed-sex services were extremely concerned about the safety and privacy of bedroom and bathroom facilities. As four out five of the women in the study had experienced physical or sexual abuse (almost always by males), this is not surprising. Sensitivity to such concerns, and the ability to provide safe detoxification facilities, would appear to be related to the ability of a treatment service to attract and retain female clients. Separate bedroom and bathroom facilities would seem to be highly desirable.

9.5.2 Option of a Female Primary Therapist

The data suggested that clients of the traditional mixed-sex services who had a male primary therapist were more than twice as likely to have relapsed to substance use six months after treatment than were those with female primary therapists. This finding was consistent with the reports of other writers. It would seem appropriate to offer female clients the option of a female therapist in a positive manner, particularly if they have issues related to sexuality or guilt and shame associated with the care of their children.

9.5.3 Women-Only Group Discussions

This recommendation is frequently cited in the literature by clinicians and researchers. The following are two examples of the many comments that women in the study made on this topic: " there was a lot of sexism and intimidation by the men in the groups" and "the males were allowed to dominate the groups and activities". The culture of substance use, particularly illicit drugs, is strongly male dominated. Women may find it difficult to assert themselves in such an environment and they may not wish to discuss issues of a personal nature. It should be relatively easy for mixed-sex programs to provide frequent groups for women only with a female therapist in which to discuss relationship, sexuality and personal empowerment issues.

9.5.4 Child-Care

The provision of child-care by all specialist alcohol and other drug services would remove a significant barrier to treatment access for women and men. While child-care is an expensive service to fund, it may be possible to share child-care with sympathetic agencies in the area.

9.5.5 Individual Counselling

The peer group model of drug and alcohol therapy based on confrontation and the break-down of denial is a male-oriented one. While many women value a mutual-help 'sharing of stories' style of group, a predominance of mixed-sex group discussions and a confrontational counselling style is not recommended. Both the research literature and the women in this study supported the importance and desirability of individual counselling. Those women attending the two services that offered individual counselling strongly endorsed it as

important to their recovery and the clients of Ward 4, Mosman Hospital frequently cited the lack of individual counselling as unsatisfactory.

9.5.6 Professional Staff

While the women in the study welcomed the inspirational personal stories and the encouragement of recovering staff members, they also emphasised the importance of empathic professionals in their treatment. Clients of the public detoxification service occasionally commented that they were prepared to forgo professional services to receive free treatment! The research literature also supports this preference for professional staff by women with substance use problems. This apparent preference may be not related so much to the training of the professional per se: it may reflect a preference for confidential individual counselling in an empathic manner, with a skills-based approach to problem resolution.

9.5.7 Specialist Counselling and Referral

The guidelines for Jarrah House on the subjects of the treatment of sexual abuse, psychiatric co-morbidity, and the importance of referral for welfare, housing, educational and vocational issues is equally valid for traditional mixed-sex alcohol and other drug treatment services.

9.6 Recommendations for Future Research of Specialist Women's Services

The feminist theory and clinical lore which have informed decisions about the provision of specialist women's alcohol and other drug treatment services have not been empirically tested in women who are severely dependent on a range of psychoactive substances and suffer from a plethora of complex attendant problems. The lessons learned over the course of the study may benefit those undertaking a replication of this or a similar study.

9.6.1 Statistical Power

As a result of practical and fiscal restraints, the sample size used in the study was only adequate to detect a 'medium' sized or larger difference between the specialist and the traditional mixed-sex services. Any future researchers should ensure that they have the required financial and practical support to be able to recruit sufficient subjects to have an eighty per cent chance of being able to detect a 'small' effect size (.25 standard deviations). This would require 200 or more

subjects per group depending upon the way in which outcome was measured (e.g. categorical versus continuous).

9.6.2 Random Allocation

The choice of a quasi-experimental design posed problems of interpretation because of the combination of differences between groups pre-treatment, and the limited possibility of statistical forms of control with the small sample sizes per group. Replication of this study should attempt to employ a randomised control trial design. As the researchers had no control over the treatment process, it was not practically possible to randomly assign clients to a specialist women's or traditional mixed-sex treatment. While it was of interest in this study to observe the capacity of the specialist service to attract and retain a group of women traditionally considered more difficult to recruit and retain in treatment, it was difficult to make causal inferences about treatment outcome.

9.6.3 Treatment Process

Related to the lack of control over the allocation of subjects to groups, was the lack of control over the implementation of the treatment process. Any future study should ensure by therapist training and treatment monitoring that a feminist empowerment model was being employed. This would ensure that the treatments were sufficiently different to provide a fair test of the relative value of an empowerment and skills-based treatment as against a more traditional confrontational treatment model based on the disease model of addiction.

9.6.4 Follow-Up

As a result of funding constraints, this study was unable to carry out a twelve month follow-up of clients. Any future study should follow patients over a longer time period, building in a 3-month telephone contact and six, twelve and twenty four month interviews to maximise the ability of the study to comment on the long-term treatment outcome. The following are some hints for enhancing follow-up contact rates in this extremely mobile and socially disadvantaged group:

- prepare the client for follow-up contact, and ensure that this is included in the consent form;

- ascertain whether the client has any travel planned during the follow-up period (consider excluding the client if she is travelling out of the State);

- collect a variety of contact information. Often the client who has an optimistic view of her post-treatment performance will only provide the names and addresses of "non-user" contacts. It is important to collect "user" and "non-user" contacts, to maximise the chance of contacting the client at a later date. The recording of the client's parents' address and phone number may be also provide a stable contact;

- provide the client with a card to send in when she changes address; a stamped rather than a franked envelope will enhance the personal nature of the contact;

- be flexible in the timing and manner of follow-up interviewing. Some interviews may need to be conducted at week-ends or evenings if the client is working full-time, or by telephone or mail if the client is out of the area;

- telephone the client on the morning of the interview to remind her of the appointment;

- if the client misses an appointment send a *handwritten* note to ask if there are any problems and to alert her that we will be in touch to make another appointment;

- where possible pay the client for follow-up interviews (this may be in the form of reimbursement for travelling expenses);

- the research co-ordinator should have appropriate data management procedures in place to ensure that interviews are being conducted according to schedule.

9.6.5 Research Questions About Treatment Content

There are vast gaps in our knowledge about a range of gender-specific issues in alcohol and other drug research. Many of these require a large-scale, long-term

prospective study over the female life-span to assess the role of substance use in the lives of women, its social meaning, the natural patterns and the causal relationship between a family history of addiction disorders, sexual assault, sexual orientation, psychopathology (such as depression) and the development of substance dependence problems.

If we confine ourselves to treatment research, the most pressing research need is an investigation of the effect of adding the specific treatment of issues for women who have experienced sexual assault on the outcome of alcohol and other drug treatment. While this study has questioned the wisdom of untrained counsellors using a confrontational style, it is unclear which is the best way to treat drug and alcohol dependent women with a history of sexual assault.

9.6.6 General Alcohol and Other Drug Research

While research into the efficacy and effectiveness of specialist women's treatment services is extremely valuable, it is even more important to build on the base of knowledge regarding the correlates, patterns and consequences of substance use for women. A constant reminder is required to all researchers to include female subjects in their studies, to analyse results by gender, and to report such findings in all presentations of their data.

APPENDIX A Consent Form and Interview Schedules

Consent Form to Participate in the Study

I _____

of _____

agree to participate in a study of treatment outcome for drug and alcohol dependent women which is being conducted by the National Drug and Alcohol Research Centre.

I agree to be interviewed about my use of alcohol and drugs, my social circumstances, and my psychological condition. I agree to information being collected about the treatment I receive during my stay in this unit. I also agree to a follow-up interview a year after my admission to see how I have fared since treatment.

I understand that:

(i) all information that is collected will be kept strictly confidential and will be used solely for research purposes;

(ii) my name will <u>not</u> be used in any publications about the study;

(iii) the research study is <u>not</u> a part of my treatment;

(iv) I am free to decline to participate in the study, if I wish, without in any way affecting the treatment I receive;

(v) if I agree to participate, I am free to withdraw from the study at any time without affecting my subsequent treatment.

I have been given an opportunity to ask any questions I have about the study.

Signed _____

Witness _____

Name of witness:

_____

Address:

_____

_____

ADMISSION INTERVIEW

1. **Demographics**

Code ☐☐☐☐

Age ☐☐

N° of days since admission ☐☐

How many times have you moved in the last two years? ☐☐

Marital status: ☐☐

Married	(01)
Separated	(02)
Divorced	(03)
Widowed	(04)
Single	(05)
De-facto	(06)

With whom have you been living in the last 6 months? ☐☐

Parents	(01)
Friend	(02)
Sexual Partner	(03)
Alone	(04)
Partner & kids	(05)
Institution	(06)
Children	(07)
Relatives	(08)
No fixed address	(09)

Sexual Orientation: ☐☐

Heterosexual	(01)
Bisexual	(02)
Lesbian	(03)

Is your partner/family supportive of your entering treatment? ☐☐

Yes (01)
No (02)
Unaware (03)

Family Background

Were your parents born in Australia? ☐☐

Yes (01)
No (02)
Aust. Aborigine (03)

If no, what is your country of origin? ☐☐

Is client fluent in English? ☐☐

Yes (01)
No (02)

2. **Obstetric History**

N°. of...

Pregnancies ☐☐

Planned pregnancies ☐☐

Terminations ☐☐

Spontaneous abortions ☐☐

Have you ever lost custody? (Yes 01, No 02) ☐☐

Children in your care: ☐☐
- under 10 years ☐☐

- N°. female ☐☐

- N°. male ☐☐

- N°. that have accompanied you to unit ☐☐

If not, where are they now? ☐☐

Father	(01)
Grandparent	(02)
Friend	(03)
Foster care	(04)
Relative	(05)

Did you use alcohol or other drugs in pregnancy? ☐☐

Yes	(01)
No	(02)

3. **Legal Circumstances**
Are you currently:

On parole/probation ☐☐

On bail ☐☐

N°. of drug convictions ☐☐

N°. of drug related convictions ☐☐

Did you support your habit by crime but not get caught? (01/02) ☐☐

Were your crimes involving: ☐☐

Person	(01)
Property	(02)
Parole/prob. violation	(03)
Fraud	(04)

Months in prison or juvenile institution? ☐☐

4. **Education**

Completed years of high school ☐☐

Other qualifications: ☐☐

Secretarial	(01)
Service industry	(02)
Trade	(03)
Diploma	(04)
Degree	(05)

5. **Employment History**

In the last six months were you? ☐☐

Employed full time	(01)
Employed part time	(02)
Unemployed	(03)
Student/trainee	(04)
Sickness benefit	(05)
Household duties	(06)
Pensioner/retired	(07)
In prison	(08)

What is your usual occupation? ☐☐

Are you currently employed? ☐☐

Yes	(01)
No	(02)

How many months since you last worked? ☐☐

What are your main sources of income/support? ☐☐

Work	(01)
Social Security	(02)
Crime/prostitution	(03)
Partner	(04)

6. **Referral** ☐☐

How did you hear about this service?

Pamphlet	(01)
Media	(02)
Personal experience	(03)
AA/NA contact	(04)
Friend/relative	(05)
G.P.	(06)
C.H.C.	(07)
Drug/Alcohol Unit	(08)
Hospital	(09)
Women's Service	(10)
Telephone counselling	(11)
Legal	(12)
Government agency	(13)

7. **Reasons for presentation**

What prompted your decision to enter treatment? ☐☐

Concerns about:

Finances	(01)
Legal pressure	(02)
Health Status	(03)
Family pressure	(04)
Children's care	(05)
Unemployment	(06)
Pressure from child protection authorities	(07)

Other .....

Why did you choose this unit? ☐☐

Close to home	(01)
Length of program	(02)
Women only	(03)
Only option given	(04)
Re-admission	(05)
Chosen by child protection or legal system	(06)

Other .....

How do you feel this centre can help you? ☐☐

Detox	(01)
Education	(02)
Time-out	(03)
Don't know	(04)

8. **Drug history**

Age when first drunk/stoned? ☐☐

Age when first aware that drugs/alcohol were a problem for you? ☐☐

Time lag to this treatment (months) ☐☐

STIGMA:

Do you feel society looks down more on women who have a problem with drugs or alcohol than they do on men? ☐☐

Yes	(1)
No	(2)
Unsure	(3)

Has this thought affected your decision to enter treatment? ☐☐

Yes	(1)
No	(2)
Unsure	(3)

Have you ever had a problem with any other drug? ☐☐

Yes	(1)
No	(2)

Is your current drug a replacement? ☐☐

Yes	(1)
No	(2)

9. **Current Drug Use**

(OTI Last Month Use)

Heroin	☐☐☐☐
Other opiates	☐☐☐☐
Alcohol	☐☐☐☐
Tranquillisers	☐☐☐☐
Barbiturates	☐☐☐☐
Hallucinogens	☐☐☐☐
Inhalants	☐☐☐☐
Amphetamines	☐☐☐☐
Cocaine	☐☐☐☐
Cannabis	☐☐☐☐
Tobacco	☐☐☐☐
Ecstasy	☐☐☐☐

Why do you think you started to drink/do drugs? ☐☐

Forget family problems	(1)
Peer pressure	(2)
Excitement	(3)
Increase socialization	(4)
Partner used	(5)
Other	

Have you had clean/sober periods? (>2 months) ☐☐

Yes	(01)
No	(02)

Was this related to: ☐☐

Pregnancy	(01)
Treatment	(02)
Willpower	(03)

Why did you bust? ☐☐

Life stressor (01)
Boredom (02)
Other .....

10. **Dependency**

Measured by SADQ/SODQ as appropriate ☐☐

11. **Treatment History**

Is this a re-admission ☐☐

Yes (01)
No (02)

Did you complete the program on the last admission? ☐☐

Yes (01)
No (02)

N°. of detox admissions? ☐☐

N°. of rehab admissions? ☐☐

N°. completed? ☐☐

N°. of TCs? ☐☐

Total n°. of months in residence? ☐☐

N°. of AA/NA meeting previously attended? ☐☐

N°. of methadone maintenance programs? ☐☐

12. **Family History**

Do any of the following members of your family have a problem with drugs/alcohol?

Father (01/02)	☐☐
Mother	☐☐
Sister	☐☐
Brother	☐☐
Child	☐☐

13. **Health**

Do you have any chronic health problems ☐☐

Yes (01)
No (02)

Did you feel healthy when you entered treatment? ☐☐
Yes (01)
No (02)

Have you ever been hospitalized for a psychiatric disorder? ☐☐

Yes (01)
No (02)

If yes: ☐☐

Schizophrenia (03)
BPAD (04)
Major depression (05)
Other .....

N°. of suicide attempts ☐☐

Method: ☐☐

OD	(01)
Cutting	(02)
Road accident	(03)
Jump from height	(04)
Gun	(05)
Hanging	(06)

Have you ever had Hepatitis B? ☐☐

Yes	(01)
No	(02)

Have ever been tested for HIV? ☐☐

Yes	(01)
No	(02)

If yes; what was the result? ☐☐

Positive	(01)
Negative	(02)
Don't know	(03)

14. **Sexual/Abuse History** ☐☐

Have you ever worked as a prostitute?

Yes	(01)
No	(02)

To support your habit? ☐☐

Yes	(01)
No	(02)

Did you work on: ☐☐

Streets	(01)
Parlours	(02)

Have you ever experienced physical/sexual abuse?

Sexual abuse as a child (01/02) ☐☐

By whom: ☐☐

Father	(01)
Step-father	(01)
Brother	(03)
Male relative	(04)
Male babysitter	(05)
Male friend	(06)
Mother	(07)
Husband	(08)
Lover	(09)
Other	

Physical abuse as a child ☐☐

By whom: ☐☐

Sexual abuse as a child ☐☐

By whom: ☐☐

Physical abuse as an adult ☐☐

By whom: ☐☐

15. **Maternal/Child Relationship Index**

This questionnaire is designed to measure the degree of contentment you have in your relationship with your child. There is no right or wrong answer. Answer each item as carefully and accurately as you can by placing a number beside each item using the key.

1. Rarely or none of the time.
2. A little of the time.
3. Some of the time.
4. A good part of the time.
5. Most or all of the time.

(Reverse scoring for negatively worded questions (b,e,f,g,h))

( ) a. I get on well with my child.

( ) b. My child is too demanding.

( ) c. I am very patient with my child.

( ) d. My child is well behaved.

( ) e. I find it difficult to express tender emotions to my child.

( ) f. I feel very angry towards my child.

( ) g. I have no clear expectations about behaviour.

( ) h. My child interferes with my other activities.

( ) i. If I am angry, my child knows exactly why.

( ) j. If rules are broken, my child knows exactly what to expect.

Compared to the "average" mother, how much do you enjoy being a parent?

Very Much	A Lot	Same as Average	Not Much	Not at All
(50)	(40)	(30)	(20)	(10)

16. **Social Support Inventory**

This questionnaire is designed to assess the support available to you and your feelings about your situation.

A. What percentage of your friends are clean/sober?

.....%

(100-75%=4, 74-50%=3, 49-25%=1, 24-0%=0)

B. What percentage of the people you live with, or are closest to, abuse drugs/alcohol?

.....%

(0-24%=4, 25-49%=3, 50-74%=1, 75-100%=0)

C. In an ordinary week, how many people whom you know (but are not necessarily close friends) would you say you have contact with?

<5	(1)
6-10	(2)
>10	(3)

D. Would you like more or less than this or is it about right for you? (persons, duration or frequency).

Less	(2)
About right	(3)
More	(1)

E. I have been talking about people you may know a little but not call them close friends. At this time last year, would you say there were more/less/same number of such people in your life?

More Now	(3)
Same	(2)
Fewer Now	(1)

F. Among your friends and family, how many people are there who are immediately available to you whom you can talk with frankly, without having to watch what you say?

None	(0)
1-2	(1)
3-5	(2)
>5	(3)

G. Would you like to have more or less people like this or is it about right for you?

Less	(2)
About right	(3)
More	(1)

H. Apart from those at home, are there people to whom you can turn in times of difficulties? Someone you can see fairly easily, that you can trust and could expect real help from in times of trouble.

No	(0)
Yes	(1)

Number .....
(>1=2, >3=3)

I. Have you asked anyone what welfare benefits you are entitled to?

No	(1)
Yes	(2)
Not required	(2)

J. Do you know where your local Community Health Centre is and what services it offers?

No	(1)
Yes	(2)

K. Do you have any religious/spiritual belief from which you draw comfort?

No	(1)
Yes	(2)

L. Do you have a local doctor in whom you have faith?

No	(1)
Yes	(2)

M. Do you use any child-care facilities?

No	(1)
Yes	(2)
Not required	(2)

N. Are there any hobbies or activities that you enjoy which you are able to do regularly?

No	(1)
Yes	(2)

Maternal/Child Relationship Index ☐☐☐

Social Support Inventory ☐☐☐

17. **Beck's Depression Inventory : Short Form** ☐☐

18. **Coopersmith's Self-Esteem Inventory** ☐☐

Thank you for your assistance

DISCHARGE INTERVIEW

1. Code ☐☐☐☐

2. **Length of stay** (days) ☐☐

3. **Detoxification details** ☐☐

Drug free	(01)
Drug assisted	(02)

4. **Sex of primary therapist** ☐☐

Female	(01)
Male	(02)

5. **Reasons for leaving** ☐☐

Completed program	(01)
To be with partner	(02)
To care for children	(03)
Take care of business	(04)
Couldn't cope	(05)
Program inappropriate	(06)
Other	

Would you have chosen to stay longer if residential child-care was available? ☐☐

Yes	(01)
No	(02)
Not applicable	(00)

Would you have preferred to be in a women-only treatment centre? ☐☐

Yes	(01)
No	(02)
Not applicable	(00)

6. How do you feel about leaving? ☐☐

Pleased	(01)
Anxious	(02)
Confident	(03)
Other	

7. **Referrals Offered?** ☐☐

Detox centre	(01)
Refuge/hostel	(02)
AA/NA	(03)
Women's halfway house	(04)
Residential rehab	(05)
Mixed halfway house	(06)
Out-patient counselling	(07)
Own care	(08)
Hospital	(09)
No referral offered	(10)

Other.....

8. **With whom will you be living?** ☐☐

Parents	(01)
Friend	(02)
Sexual partner	(03)
Alone	(04)
Partner & Children	(05)
Institution	(06)
Children	(07)
Relatives	(08)
No firm arrangement	(09)

9. **Usefulness of treatment**

How useful did you find the following aspects of your treatment program using the following rating scale?

0=not at all useful → 5=very useful
6=not offered and not thought valuable
7=not offered but thought would have been valuable.

Residential childcare	☐
Parenting skills	☐
Addiction issues	☐
Women's issues	☐
Social & survival skills	☐
Assertiveness training	☐
Health/dental care	☐
Relaxation training	☐
House meetings	☐
Physical activities	☐
Individual counselling	☐
AA/NA meetings	☐
Non-AA/NA self-help groups	☐
Family therapy	☐
Clergy group/religious study	☐

Attkisson Client Satisfaction Questionnaire ☐☐

10. **Health**

Do you feel any different physically than you did on admission? ☐☐

Much better	(01)
Better	(02)
No different	(03)
Worse	(04)
Much worse	(05)

11. **Beck's Depression Inventory : Short Form** ☐☐

12. **Coopersmith's Self-Esteem Inventory** ☐☐

13. **Situational Confidence Questionnaire** ☐☐

Thank you for your assistance

FOLLOW-UP INTERVIEW

1. Code ☐☐☐☐

2. **Living Arrangements**

How many times have you moved in the last six months? ☐☐

Who are you currently living with? ☐☐

Parents	(01)
Friend	(02)
Sexual partner	(03)
Alone	(04)
Partner & kids	(05)
Institution	(06)
Children	(07)
Relatives	(08)
No fixed address	(09)

3. **Current Drug Use** (OTI Drug Use)

Heroin ☐☐☐☐

Other opiates ☐☐☐☐

Alcohol ☐☐☐☐

Tranquillisers ☐☐☐☐

Barbiturates ☐☐☐☐

Hallucinogens ☐☐☐☐

Inhalants ☐☐☐☐

Amphetamines ☐☐☐☐

Cocaine ☐☐☐☐

Cannabis ☐☐☐☐

Tobacco ☐☐☐☐

Ecstasy ☐☐☐☐

Analgesics ☐☐☐☐

Have you used any drugs/alcohol since discharge? ☐☐

Yes (01)
No (02)

If yes, how long after you were discharged did you first use? (days) ☐☐

Do you believe your drug/alcohol use is under control? ☐☐
(01 yes, 02 no)

Please give the reasons for your answer.

_____

_____

_____

4. **Situational Confidence Questionnaire** ☐☐

5. **Schedule of Life Stressors** ☐☐

6. **Treatment Since Discharge**

Number of detox. admissions ☐☐

Number completed ☐☐

Number of programs > 1 week ☐☐

Number completed ☐☐

Number of weeks in TC programs ☐☐

Names of each centre (for later coding re. orientation)

_____

_____

7. **On-going treatment components**

What aspects of the treatment have you continued since discharge?

Out-patient counselling (note by whom)	(01)	☐☐
Self-esteem group	(02)	☐☐
Exercise	(03)	☐☐
Family therapy	(04)	☐☐
Relaxation training	(05)	☐☐
Spiritual guidance	(06)	☐☐
Regular AA/NA meetings (note frequency of meeting attendance)	(07)	☐☐

Other.....

8. **Legal**

Are you currently on:

Probation	☐☐
Parole	☐☐
Bail (yes (01) no (02))	☐☐

Since discharge

N° of drug convictions	☐☐
N° of drug-related convictions	☐☐
N° of months in jail	☐☐
	☐☐

What was the offence?

Person	(01)
Property	(02)
Fraud	(03)

Other.....

9. **Obstetric History**

Since discharge have you had any of the following? (record number)

Planned pregnancy ☐☐

Unplanned pregnancy ☐☐

What was the outcome of the pregnancy ☐☐

Miscarriage	(01)
Termination	(02)
Stillbirth	(03)
Live birth	(04)

Are there any problems with the child? ☐☐

(01 yes, 02 no)

10. **Employment History**

In the last 6/12 months, how many months were you:

Employed full-time ☐

Employed part-time ☐

Unemployed ☐

Student/Trainee ☐

Sickness benefit ☐

Household duties ☐

Pensioner/retired ☐

In prison ☐

Are you currently employed? (01/02) ☐☐

What is your main source of income/support?: ☐☐

Social security	(01)
Employment	(02)
Partner	(03)
Crime/prostitution	(04)

11. **Health**

How do you feel physically compared to when you were discharged?

Much worse	(01)
Worse	(02)
No change	(03)
Better	(04)
Much better	(05)

☐☐

Have you suffered any serious or chronic illness since discharge? (01/02) ☐☐

Record the nature of condition:

_____

_____

If yes; was it related to drug use? (01/02) ☐☐

Have you tested for HIV infection (AIDS) in the last 6 months? (01/02) ☐☐

What was the result? ☐☐

Negative	(01)
Positive	(02)
Unknown	(03)

12. **Usefulness of Treatment**

In retrospect how useful do you now rate the following aspects of your treatment program?
0=not at all useful → 5=very useful, 6=not offered and not thought useful, 7=not offered but would have been useful

Residential childcare	☐
Parenting skills	☐
Addiction issues	☐
Women's issues	☐
Social & survival skills	☐
Assertiveness training	☐
Health care	☐
Relaxation training	☐
House meetings	☐
Physical activities	☐
Individual counselling	☐
AA/NA	☐
Unstructured self-help groups	☐
Family Therapy	☐
Clergy Group	☐

The following scales to be administered in random order.

13. **Beck's Depression Inventory : Short Form** ☐☐

14. **Coopersmith's Self-Esteem Inventory** ☐☐

15. **Maternal/Child Relationship Index** ☐☐

16. **Social Support Inventory** ☐☐

Thank you for your assistance

COLLATERAL INTERVIEW

Recently your partner/friend/relative did an interview with us. At that time they gave permission for us to ask you some questions about their life in the last six months. Some of these questions are rather personal. However, you can be assured that any information you give here is completely **private and confidential** i.e. it will not be given back to your partner/relative/friend, reported in any way by which you can be identified or passed on to any government agency. I understand you may not be absolutely sure of some of the information, but please give your best estimate. Do you have any questions?

Subject code _____

Relationship to client _____

Interview method _____

Follow-up period _____

How long ago did you last see her _____

How many times a week do you usually see her _____

Drug Use

During the last six months has your partner/friend/relative used any of the following drugs? (please circle correct response)

1. Heroin

No
Yes occasionally
frequently
Don't know

2. Opiates other than heroin (e.g. street methadone, morphine)

No
Yes occasionally
frequently
Don't know

3. Alcohol

No
Yes occasionally
frequently
Don't know

4. Cannabis

No
Yes occasionally
frequently
Don't know

5. Amphetamines (speed)

No
Yes occasionally
frequently
Don't know

6. Cocaine

No
Yes occasionally
frequently
Don't know

7. Tranquillisers (serepax, normison, valium, rohypnol)

No
Yes occasionally
frequently
Don't know

8. Tobacco

No
Yes occasionally
frequently
Don't know

General

How many times has she moved in the last six months?

_____

How much of the last 6 months has she been employed?
(full-time/part-time/student)

_____

Do the people closest to her (partner/friend) abuse drugs or alcohol?

No
Yes
Don't know

Has she committed any crimes during the last six months? (fraud, break & enter, dealing)

No
Yes
Don't know

Has she had any unexplained absences (more than 1 day) during the last six months? (e.g. disappeared for a few days with no reasonable explanation)

No
Yes
Don't know

During the last six months, how would you describe her physical health?

Excellent
Good
Fair
Poor

During the last six months, do you believe she has had any serious stressful incidents in her life? (death or separation from loved one, court case, dispute with someone close to her etc.)

No
Yes
Don't know

Do you have any general comments that you would like to make?

Thank you for your assistance

APPENDIX B Psychometric Properties of Maternal/Child Relationship Index

The particular parenting concerns of women with drug and alcohol problems are rarely addressed in traditional mixed-sex treatment services.[1] The magnification of existing feelings of guilt, shame and failure surrounding their maternal role, if left unaddressed, may negatively affect treatment outcome. The adequacy of substance abusing women as mothers has been questioned[2] and the legacy of dysfunctional child-rearing patterns for the child may be malnutrition, developmental delays, learning disorders and future substance abuse[3].

There have been no treatment outcome studies reporting the effect of interventions addressing parenting skills in substance dependence treatment programs. The sparse literature available contains only descriptive reports of programs[4] or accounts of the therapeutic issues.[2,5]

The provision of a parenting skills discussion group at Jarrah House suggested that the impact of this aspect of the program on some of the attitudes and behaviours regularly addressed in that group, should be measured during the evaluation.

As the use of standardised instruments was preferred by the researchers, the available instruments designed to measure the parent/child relationship were reviewed. The more reliable and valid instruments to measure parenting skills such as the Home Observation for the Measure of the Environment,[6] and the Baumrind Parent Rating Scales[7] require two independent observers to rate aspects of the parent-child interaction over a period of time. While this is an optimal manner to measure the quality of the relationship more objectively, this methodology was not feasible for the current study. An extremely well-researched and validated instrument that does not require behavioural observation is the Parenting Stress Index.[8] With 120 items in the shortened version it was considered too long for the present study, but items from this scale were incorporated into the present instrument. Similarly, domains from the Michigan Screening Profile of Parenting[9] were adapted for this questionnaire.

A further difficulty was that only a small number of instruments had been used among a substance dependent population. Researchers occasionally developed their own measures of parental interaction and maternal attitude, but did not supply information on their psychometric properties.[4] Two instruments which have been used in research with women who have alcohol or other drug problems, The Maryland Parent Attitude Survey[10] and the Mother-Child Relationship Evaluation,[11] only measure aspects of parenting style and not typical

behaviour, emotional responses or enjoyment of the parental role which were of central interest in this study.

The Maternal/Child Relationship Index

This questionnaire is designed to measure the degree of contentment you have in your relationship with your child. There is no right or wrong answer. Answer each item as carefully and accurately as you can by placing a number beside each item using the key.

1. Rarely or none of the time.
2. A little of the time.
3. Some of the time.
4. A good part of the time.
5. Most or all of the time.

(Reverse scoring for negatively worded questions (b,e,f,g,h))

along	( ) a.	I get on well with my child.
demand	( ) b.	My child is too demanding.
patient	( ) c.	I am very patient with my child.
behave	( ) d.	My child is well behaved.
emotion	( ) e.	I find it difficult to express tender emotions to my child.
angry	( ) f.	I feel very angry towards my child.
expect	( ) g.	I have no clear expectations about behaviour.
acts	( ) h.	My child interferes with my other activities.
know	( ) i.	If I am angry, my child knows exactly why.
rules	( ) j.	If rules are broken, my child knows exactly what to expect.

Compared to the "average" mother, how much do you enjoy being a parent?

Very Much	A Lot	Same as Average	Not Much	Not at All
(50)	(40)	(30)	(20)	(10)

The italicised items refer to the abbreviations used in the graphs and tables to follow for each items.

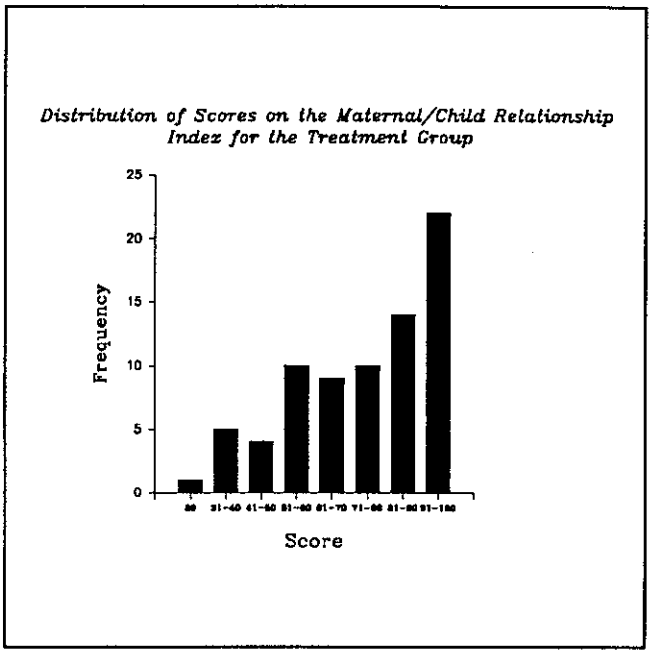
The instrument was primarily designed to allow the subject to rate her enjoyment or satisfaction in the maternal role. Therefore, these final items account for half of the overall score. The other 10 items were intended to measure aspects of the maternal-child relationship that are emphasised in the literature and in the Jarrah House parenting group. These include consistency of discipline (*expect, rules, behave*), dealing with maternal anger (*angry, know*), ability to express positive emotions (*emotion*), and the bond between the parent and child (*along, patient, demand, acts*). The subject was asked to focus on one particular child while answering the questions. The instrument performed equally well in personal and telephone interviews and as a mailed-out self-completion questionnaire. As time was important in the present study, on average the items took between five and ten minutes to complete.

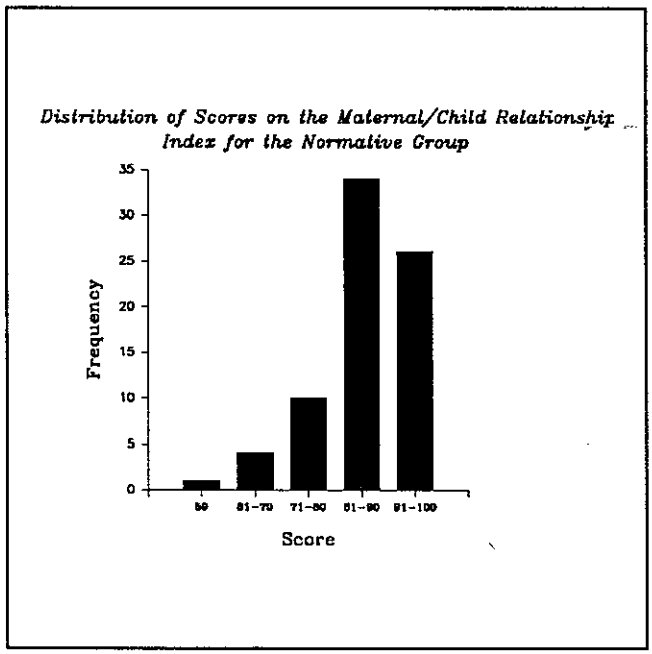
Psychometric Properties

The clinical sample of women in treatment is described in chapter 6 of this monograph.

The normative sample was recruited from a group of registered nurses from around the state of New South Wales who were attending post-graduate courses at the New South Wales College of Nursing. A group of nurses was selected as an appropriate normative group as nurses represented the largest occupational group among the clinical sample. Seventy-five nurses volunteered to complete the test items on two occasions, one week apart, for which they received no payment.

The average age of the sample was 39.7 years (range 24-56, sd 7.9 years) and 71% were in full-time employment, with the remainder being part-time or casual workers. They had an average of 2.4 children (range 1-5, sd 1), with 44% having a child/ren under 5 years, 52% a teenage child/ren, and 51% a child/ren over the age of 15 years.





Test-Retest Reliability

Pearson product-moment correlation co-efficients were calculated for the scores on each of the items of the Maternal/Child Relationship Index, obtained from the normative group subjects on the two occasions. The results are presented in Table B.1.

Table B.1

Test-Retest Reliability for Normative Sample

Item	Correlation
Along	0.77
Demand	0.67
Patient	0.67
Behave	0.76
Emotion	0.84
Angry	0.71
Expect	0.54
Acts	0.63
Know	0.71
Rules	0.71
Average	0.83

Internal Reliability

The co-efficient alpha for all items for the treatment group was .77, for the normative group .73 and the co-efficient alpha for all subjects combined was .58.

Factor Structure

A factor analysis with varimax rotation was conducted with the combined results of 150 completed questionnaires. The results are presented in Table B.2. As can be seen, three factors emerged from the analysis. Factor I, which accounted for 17.5% of the variance, may be conceptualised as "perceived child behaviour". Factor II loads on the concepts of "dealing with emotion" and accounts for 16.4% of the variance. Factor III may be conceived as the "parental bond" and loads on items tapping the quality of the relationship and attitudes to discipline. The alpha co-efficient for the three factors were respectively, 0.669, 0.623 and 0.701.

Table B.2

Factor Structure of the Maternal/Child Relationship Index

Item	Factor I	Factor II	Factor III
along	0.18	0.24	0.63
demand	0.72	0.12	0.36
patient	0.34	0.37	0.49
behave	0.78	0.05	0.07
emotion	0.29	0.62	0.19
angry	0.49	0.61	0.01
expect	0.05	-.03	0.56
acts	0.38	-.01	0.63
know	-.21	0.79	0.14
rules	-.05	0.23	0.76
average	0.34	0.38	0.57
Eigen values (sums of latent roots)	3.97	1.14	1.08

Validity

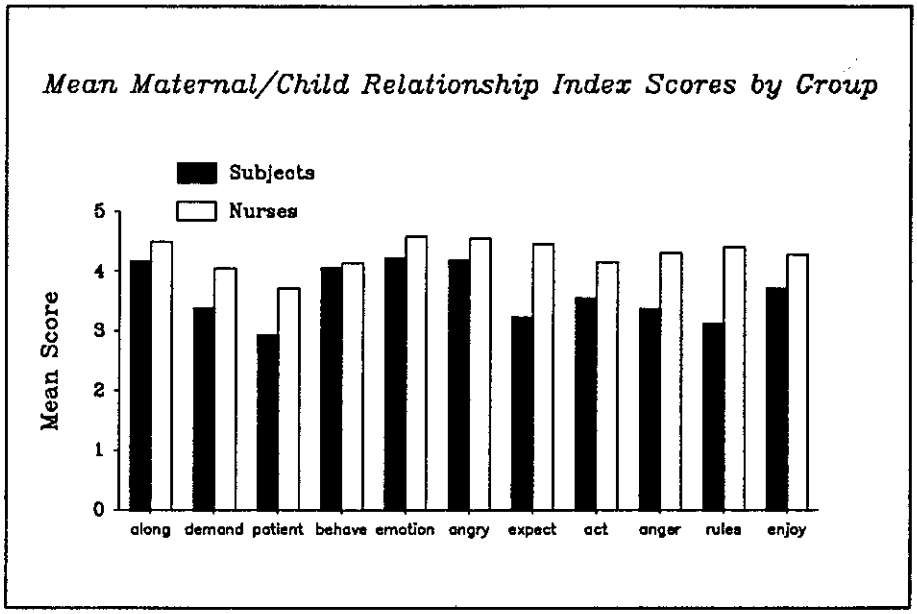
There were no standardised instruments available for construct validation procedures. Content validity was assessed by requesting comment on the instrument by staff members who offered the parenting discussion group at Jarrah House, to ensure that it measured related issues and had face validity for the subjects. There was an oblique measure of convergent validity for the Maternal/Child Relationship Index in that it performed in a manner consistent with other measures of treatment outcome at the 6-month follow-up.

Test Score Predictor for the Treatment Group

Despite reported relationships between psychopathology[12] and childhood sexual assault[13] and disturbed parenting style, these were not predictive of a lower range score on the current instrument. Only a maternal age under 25 years (χ^2 7.7, p

<.01, odds ratio 3.73, 95% confidence interval [1.42-9.82]) and maternal unemployment (χ^2 4.1, p <.04, OR: 2.05, CI: [1.02, 4.15]) were predictive of a score in the lower third of the range.

Comparison Between Normative and Client Groups



On all of the items, the normative group were significantly more likely to report in a positive manner a good part, most or all of the time, than were the women in alcohol or other drug treatment (See Table B.3). This was consistent with other research which has found that women dependent on psychoactive drugs have problematic parent-child relationships.[14,15]

Table B.3

Comparisons Between Subject and Normative Group Scores on Individual Items

Item	χ^2	P value	Odds Ratio	95% Conf. Interval
Along	16.7	<.001	7.0	[2.5, 19.5]
Demand	13.4	<.001	3.5	[1.8, 7.1]
Patient	8.6	<.01	2.7	[1.4, 5.2]
Behave	7.6	<.01	2.8	[1.3, 6.1]
Emotion	7.6	<.01	3.5	[1.4, 8.9]
Angry	11.2	<.001	4.2	[1.7, 10.1]
Expect	29.1	<.001	8.4	[3.6, 19.2]
Acts	9.5	<.001	3.0	[1.47, 6.1]
Know	18.1	<.001	5.1	[2.3, 11.2]
Rules	33.0	<.001	10.1	[4.3, 29.9]
Average	17.7	<.001	5.5	[2.4, 12.6]

APPENDIX C Psychometric Properties of Social Support Inventory

The concept of social support as a determinant of mental and physical well-being has found increasing acceptance in a wide variety of settings. Social support has been reported to lower general mortality,[1] to protect against depression[2] and against mental illness and psychological distress in general,[3,4] to reduce pregnancy complications,[5] and to prevent or ameliorate a number of other ailments and disorders.[6] Research attempting to clarify the mechanism by which social support impacts on health has reported frequently contradictory results. It remains unclear whether social support acts as a "buffer" against stress and under what circumstances, whether the notion of support is primarily on the character of the individual, and whether intimate or casual but structured relationships are more important.[6]

The role of social support in the outcome of alcohol and other drug treatment has been discussed by a number of researchers and clinicians. In both community[7] and treatment service settings low levels of social support has been linked to increased likelihood of high levels of substance use, relapse following treatment, psychological distress and suicide.[8]

A number of aspects of social support have been identified as most likely to affect the treatment outcome of women with alcohol and other drug problems. The more important aspect of social networks appears to be their quality rather than their size alone.[9] Women who are dependent on alcohol or other drugs are more likely to have a spouse with similar problems than are men and this makes it less likely that their spouses will support their efforts to achieve abstinence.[10] The failure of a spouse to support treatment has been linked to relapse to substance use by women following treatment.[11] In addition, spouses' and closest friends' drinking has been found to predict negative consequences of drinking amongst women in the community.[12] Women in substance dependence treatment frequently have poor quality and insecure housing, serious financial problems, a fear of contacting government welfare services (particularly if they have children), few readily employable skills and mix in a social group primarily made up of other high-risk alcohol and other drugs users.[13] Other aspects of social support that have been found to affect general well-being and relapse to substance misuse include the number of people that women feel close to,[14] the perceived supportiveness of those relationships,[15] and shared activities and recreation that do not involve on alcohol and other drug use.[16]

The requirements of an instrument to assess the social support of the women in the current study were that it be reliable and valid, be quick to administer, and

that it includes the issues relevant to women with alcohol and other drug dependence. No single available instrument was found to meet these criteria. While many studies included questions tapping social support they did develop a cohesive instrument.[8,14] Instruments such as the Social Adjustment Scale Self-Report which have reportedly been used with substance dependent populations have an overwhelmingly heterosexual focus and centre on social functioning rather than social support.[17]

In an effort to make the Social Support Inventory culturally appropriate it was largely based on an instrument developed to assess the relationship between deficiencies in social support and non-psychotic disorders in a general population survey, The Interview Schedule of Social Interactions (ISSI).[18] The questionnaire was designed to assess the social support perceived by the subject to be available to them and their feelings about their social situation. As the ISSI was not specifically designed for an alcohol and other drug dependent population, other items suggested in the literature were included.

The Social Support Inventory

This questionnaire is designed to assess the support available to you and your feelings about your situation.

A. What percentage of your friends are clean/sober?
(friend)

.....%

(100-75%=4, 74-50%=3, 49-25%=1, 24-0%=0)

B. What percentage of the people you live with, or are closest to, abuse drugs/alcohol?
(live)

.....%

(0-24%=4, 25-49%=3, 50-74%=1, 75-100%=0)

C. In an ordinary week, how many people whom you know (but are not necessarily close friends) would you say you have contact with?
(contact)

<5	(1)
6-10	(2)
>10	(3)

D. Would you like more or less than this or is it about right for you? (persons, duration or frequency).
(OK)

Less	(2)
About right	(3)
More	(1)

E. I have been talking about people you may know a little but not call them close friends. At this time last year, would you say there were more/less/same number of such people in your life?
(lastyr)

More Now	(3)
Same	(2)
Fewer Now	(1)

F. Among your friends and family, how many people are there who are immediately available to you whom you can talk with frankly, without having to watch what you say?
(talk)

None	(0)
1-2	(1)
3-5	(2)
>5	(3)

G. Would you like to have more or less people like this or is it about right for you?
(enough)

Less	(2)
About right	(3)
More	(1)

H. Apart from those at home, are there people to whom you can turn in times of difficulties? Someone you can see fairly easily, that you can trust and could expect real help from in times of trouble.
(turnto)

No	(0)
Yes	(1)

Number .....
(>1=2, >3=3)

I. Have you asked anyone what welfare benefits you are entitled to?
(welfare)

No	(1)
Yes	(2)
Not required	(2)

J. Do you know where your local Community Health Centre is and what services it offers?
(chc)

No	(1)
Yes	(2)

K. Do you have any religious/spiritual belief from which you draw comfort?
(relig)

No	(1)
Yes	(2)

L. Do you have a local doctor in whom you have faith?
(GP)

No	(1)
Yes	(2)

M. Do you use any child-care facilities?
(ccare)

No	(1)
Yes	(2)
Not required	(2)

N. Are there any hobbies or activities that you enjoy which you are able to do regularly?
(hobbies)

No	(1)
Yes	(2)

The italicised items refer to the abbreviations used in the graphs and tables to follow for each items.

The items included ask about[a]: the substance use of sexual partners or closest friends and the womens social group in general (*friend, live*);[19] the degree of general social contact, the number of confidantes and trusted people available to the subject, whether that is comfortable for her and if this has changed recently (*contact, ok, lastyr, talk, enough, turnto*);[18] the availability of institutional assistance (*welfare, chc, ccare*);[6] and regular involvement in drug-free activities (*hobbies*).[16] The instrument performed equally well in personal and telephone interviews and as a mailed-out self-completion questionnaire. As time was important in the present study, on average the items took between five and ten minutes to complete.

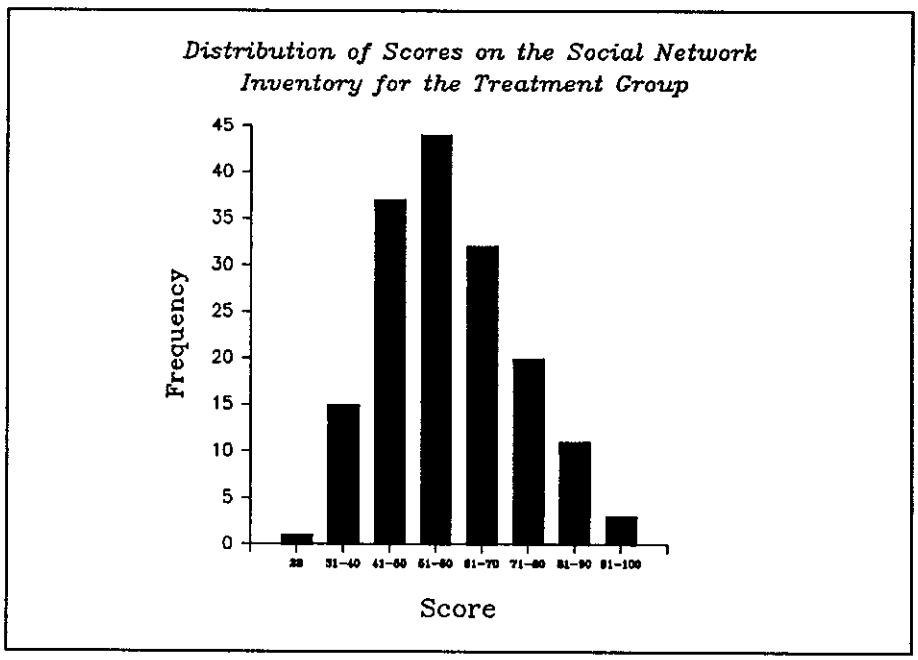
[a] *The reference suggesting these issues for inclusion is noted next to the item names.*

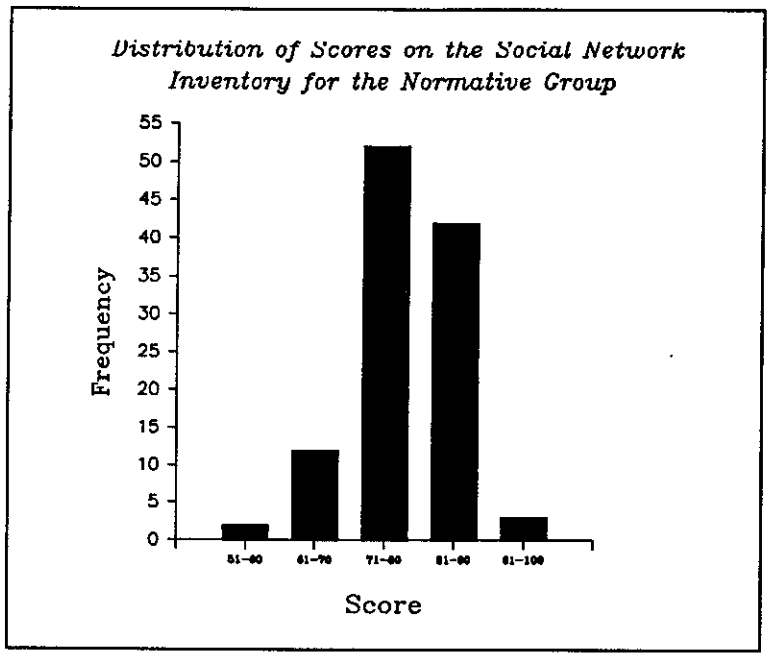
Psychometric Properties

The clinical sample of women in treatment is described in chapter 6 of this monograph.

The normative sample was recruited from a group of registered nurses from around the state of New South Wales who were attending post-graduate courses at the New South Wales College of Nursing. A group of nurses was selected as an appropriate normative group as nurses represented the largest occupational group among the clinical sample. Seventy-five nurses volunteered to complete the test items on two occasions, one week apart, for which they received no payment.

The average age of the sample was 39.7 years (range 24-56, sd 7.9 years) and 71% were in full-time employment, with the remainder being part-time or casual workers. They had an average of 2.4 children (range 1-5, sd 1), with 44% having one or more children under 5 years, 52% one or more teenage children, and 51% children over the age of 15 years.





Test-Retest Reliability

Pearson product-moment correlation co-efficients were calculated for the scores on each of the items in the Social Support Inventory, obtained from the normative group subjects on the two occasions. These are presented in Table C.1.

Table C.1

Test-Retest Reliability for Normative Sample

Item	Correlation
Friend	0.93
Live	0.99
Contact	0.57
OK	0.62
Lastyr	0.53
Talk	0.70
Enough	0.81
Turnto	0.74
Welfare	0.65
CHC	0.82
Religion	0.94
GP	0.94
Ccare	0.96
Hobbies	0.87

Psychometrics: Social Support Inventory

Internal Reliability

The co-efficient alpha for all items for the treatment group was .64, for the normative group .34 and the co-efficient alpha for all subjects combined was .62.

Factor Structure

A factor analysis with varimax rotation was conducted with the combined results of 278 completed questionnaires. The results are presented in Table C.2. As can be seen, two factors emerged from the analysis. Factor I, which accounted for 24.8% of the variance, may be conceptualised as "involvement in a social world of substance dependence". Factor II loads on the concepts of having enough people to talk to and rely on. This accounts for 16.5% of the variance. The alpha co-efficient for the two factors were 0.71 and 0.75.

Table C.2

Factor Structure of the Social Support Inventory

Item	Factor I	Factor II
Friend	0.67	0.28
Live	0.64	0.16
Contact	0.28	0.42
OK	0.39	0.41
Lastyr	0.37	0.11
Talk	0.31	0.69
Enough	0.47	0.61
Turnto	0.18	0.69
Welfare	-.04	0.50
CHC	0.64	0.01
Relig	-.04	0.21
GP	-.01	0.33
Ccare	-.62	0.37
Hobbies	0.40	0.39
Eigen values (sums of latent roots)	2.97	2.48

Validity

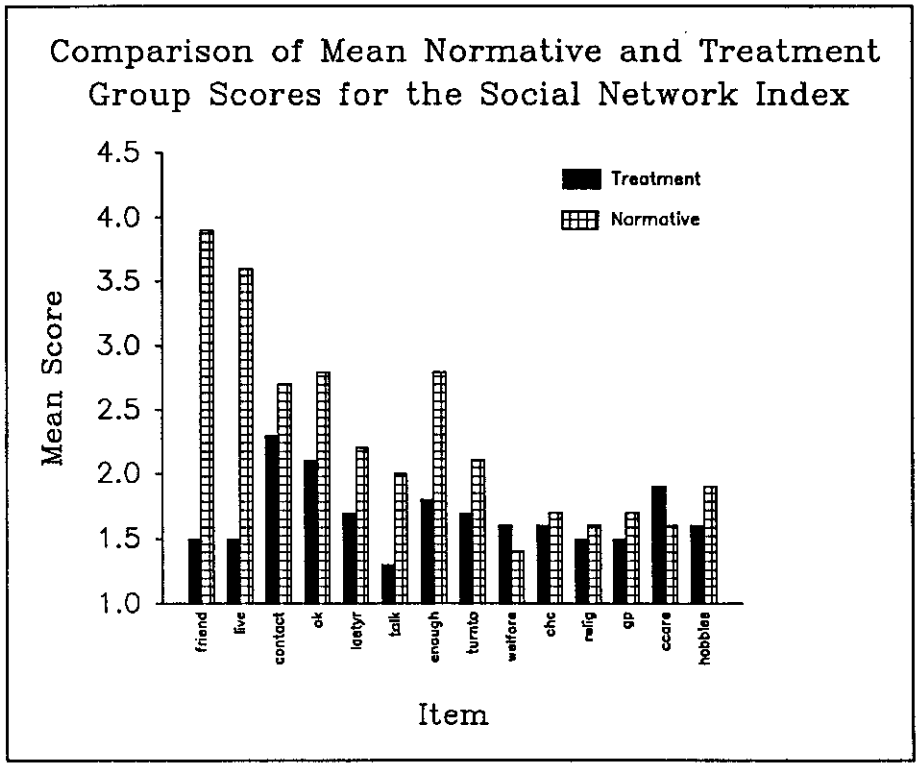
There were no standardised instruments available for construct validation procedures. Content validity was assessed by requesting comment on the instrument by staff members of the treatment services and that it had face validity

for the subjects. There was an oblique measure of convergent validity for the Social Support Inventory in that it performed in a manner consistent with other measures of treatment outcome at the 6-month follow-up.

Test Score Predictor for the Treatment Group

A number of the expected predictors of impoverished social support, such as youth and opiate dependence, were not found in this study. Only a history of ever having been admitted to a psychiatric hospital (χ^2 6.51, p <.01, odds ratio 2.98, 95% confidence interval [1.26-6.98]) and unemployment (χ^2 6.15, p <.01, OR: 2.59, CI: [1.21, 5.57]) were predictive of a score in the lower third of the range.

Comparison Between Normative and Client Groups



On all of the items, except contact, chc and religion the normative group were significantly more likely to report having a more positive social support, than were the women in alcohol or other drug treatment. However, the normative group of nurses were significantly less likely to have a general medical practitioner whom they have faith in or to have hobbies than were the group in alcohol and other drug treatment (See Table C.3). This was generally consistent with other research which has found that women dependent on psychoactive

drugs have poorer quality social support than women in the community.[8,12,14] The choice of nurses for the normative group for a social support inventory may not have been ideal as the stress and frustration felt by many nurses in their professional lives may have made them unrepresentative of women in the general community.

Table C.3

Comparisons Between Subject and Normative Group Scores on Individual Items

Item	χ^2	P value	Odds Ratio	95% Conf. Interval
Friend	95.5	<.001	15.4	[8.5, 27.9]
Live	70.3	<.001	10.5	[5.8, 19.1]
OK	42.0	<.001	6.4	[3.5, 11.7]
Lastyr	43.3	<.001	7.8	[4.0, 15.4]
Talk	31.8	<.001	4.2	[2.5, 6.9]
Enough	63.9	<.001	10.3	[5.5, 19.2]
Turnto	9.2	<.01	2.2	[1.3, 3.8]
Welfare	6.5	<.01	1.8	[1.1, 3.1]
GP	8.3	<.01	0.5	[0.3, 0.8]
Ccare	34.2	<.001	5.4	[2.9, 9.7]
Hobbies	25.2	<.001	0.2	[0.1, 0.4]

APPENDIX D Details of Statistical Analyses: Client Characteristics

Tables 1-5 provide more details of the statistical analyses examining the differences between the clients of Jarrah House and those of the traditional mixed-sex services.[a]

Statistical Procedures

Three types of data analysis were performed. First, descriptive statistics were calculated on the characteristics of the whole sample. Second, Jarrah House (JH) and the comparison services (CS) samples were compared on individual characteristics using χ^2 and t-tests. No correction was applied to adjust for the number of tests as the purpose of these analyses was largely exploratory, that is, to identify potential variables that discriminated between the characteristics of women attending specialist women and mixed-sex services. Confidence intervals were calculated around each difference or odds ratio to indicate the degree of uncertainty surrounding the estimates and to assist in the interpretation of "non significant" results, especially for comparisons of JH and CS on categorical dependent variables. Since a sample size of n=80 provides modest statistical power for medium sized differences, the upper limit of the 95% confidence interval indicated the largest difference that was consistent with the sample result. Third, a subset of the variables which best discriminated between JH and the CS, was entered into a logistic regression analysis using the LOGIT module of SYSTAT. These variables were: age classified into three categories (<25 years, 26-35 years, >35 years), dependent children or not, sexual abuse in childhood or not, sexual orientation (heterosexual or bisexual/ lesbian), and maternal history of substance abuse or not. The purpose of this analysis was to discover how these variables discriminated between JH and the CS when considered simultaneously as a set.

[a] *For further details see Copeland, J. & Hall, W. (1992). A comparison of women seeking drug and alcohol treatment in a specialist women's and two traditional mixed-sex treatment services. British Journal of Addiction, 87 (7), 65-74.*

Table D.1

Demographic Characteristics by Type of Treatment

	JH (n)	CS (n)	Odds Ratio	95% Confidence Interval
Age Mean (sd)	30.3 (7)	31.4 (8)		
Stable Relationship	14	17	0.79	[0.36, 1.74]
Lesbian	17	5	4.05	[1.41, 11.60]
Dependent Children	43	28	2.16	[1.14, 4.08]
Ever Lost Custody of their Children	18	12	1.50	[0.62, 3.63]

Table D.2

Lifetime History of Sexual/Physical Abuse by Type of Treatment

	JH (n)	CS (n)	Odds Ratio	95% Confidence Interval
Sexual Abuse in Childhood	45	30	2.14	[1.14, 4.03]
Sexual Abuse in Adulthood	39	39	1.00	[0.54, 1.86]
Physical Abuse in Childhood	37	25	1.89	[0.89, 3.61]
Physical Abuse in Adulthood	53	56	0.84	[0.43, 1.63]

Table D.3

Family History of Substance Use Problems by Type of Treatment

	JH (n)	CS (n)	Odds Ratio	95% Confidence Interval
Positive Maternal Family History	36	22	2.16	[1.12, 4,18]
Positive Paternal Family History	43	36	1.42	[0.76, 2.65]
Positive Sibling Family History	44	42	1.11	[0.57, 2.14]

Table D.4

Depression and Self-Esteem Scores by Type of Treatment

	JH (n)	CS (n)	Odds Ratio	95% Confidence Interval
Beck Depression Inventory (SF) Mean (sd)	23 (7)	21 (8)		[-0.33, 4.45]
Coopersmith Self-Esteem Inventory Mean (sd)	27 (16)	33 (19)		[-0.01, 10.80]
Proportion of Clients With Suicide Attempts	53	43	1.69	[0.89, 3.20]

Table D.5

Logistic Regression Analysis Predicting Admission to JH or CS

Variable	Odds Ratio	Lower Limit 95% Confidence Interval	Upper Limit 95% Confidence Interval	t-Test
Age	0.72	0.43	1.22	-1.23
Children	2.04	0.99	4.23	1.92
CSA	1.89	0.95	3.76	1.82
Lesbian	3.26	1.29	8.23	2.51*
MFH	2.72	1.17	6.33	2.32*

χ^2 (6 df) = 20.74 p<.01 (* Significant at p <.05)

Age: 1. <25 yrs; 2. 26-35 years; 3. >35 yrs.
Dependent Children: 1. 0; 2. ≥1.
Childhood Sexual Abuse: 1. absent; 2. present.
Lesbian: 1. heterosexual; 2. bisexual/absent.
Maternal Family History: 1. absent; 2. positive maternal family history.
Dependent Variable: 1. Jarrah House; 2. Comparison mixed-sex services.

APPENDIX E Details of Statistical Analyses: Impact Evaluation

Treatment Drop-Out

Tables 1-4 provide more details of the statistical analyses examining the predictors of treatment drop-out of the clients of Jarrah House and those of the traditional mixed-sex services.[a]

Data Analysis

Two types of analysis were performed. Initially, the samples were compared on individual characteristics using χ^2 and t-tests, by type of treatment and whether or not they stayed more than five days in treatment. No correction was applied to adjust for the number of tests as the purpose of these analyses was largely exploratory, that is, to identify potential variables that discriminated between the groups. Second, odds ratios and/or confidence intervals were calculated around each difference to indicate the degree of uncertainty surrounding the estimates and to assist in the interpretation of "non significant" results, especially for comparisons using categorical dependent variables. The upper limit of the 95% confidence interval indicated the largest difference that was consistent with the sample result. Third, a subset of the variables which best discriminated between the COMP and the DO groups based on univariate chi square analyses, was entered into a logistic regression analysis using the LOGIT module of SYSTAT. The purpose of this analysis was to discover how these variables discriminated between the COMP and the DO groups when considered simultaneously as a set.

[a] *For further details see Copeland, J. & Hall, W. (1992). A comparison of predictors of treatment drop-out of women seeking drug and alcohol treatment in a specialist women's and two traditional mixed-sex treatment services. British Journal of Addiction, 87 (6), 883-890.*

Table E.1

Demographic Characteristics by Treatment Drop-Out

	DO† (n)	COMP† (n)	Odds Ratio	95% Confidence Interval
Age Mean (sd)	29.7 (9)	30.8 (8)		
Married	24	13	1.99	[0.97, 4.06]
Lesbian	6	21	3.88	[1.48, 10.15]
Dependent Children	71	72	0.97	[0.63, 1.50]

† DO = drop-out of treatment < 5 days COMP = stay in treatment ≥ 5 days

Table E.2

Lifetime History of Sexual/Physical Abuse by Treatment Drop-Out

	DO (n)	COMP (n)	Odds Ratio	95% Confidence Interval
Sexual Abuse in Childhood	59	73	0.69	[0.44, 1.08]
Sexual Abuse in Adulthood	58	83	0.53	[0.34, 0.83]
History of Prostitution	55	45	1.33	[0.83, 2.15]

Table E.3

Interaction Between Client Characteristics & Type of Treatment on Treatment Completion

	JH (n)	CS (n)	Odds Ratio	95% Confidence Interval
Lesbian (COMP)	17	4	5.13	[1.64, 16.02]
Dependent Children (COMP)	44	28	2.27	[1.20, 4.29]
Sexual Abuse in Childhood (COMP)	44	29	2.15	[1.14, 4.05]

Table E.4

Logistic Regression Analysis Predicting Treatment Drop-Out

Variable	Odds Ratio	Lower Limit 95% Confidence Interval	Upper Limit 95% Confidence Interval	t-Test
Age	1.40	0.21	9.33	0.35
Employment	5.70	3.33	9.99	6.24*
Drug	1.30	0.93	1.80	-1.74
AA/NA	1.50	0.20	10.60	-3.85
ASA	1.70	1.03	2.80	-2.19*

χ^2 (5 df) = 64.90 p<.01 (* Significant at p <.05)

Age: 1. <25 yrs; 2. 26-35 years; 3. >35 yrs.
Employed: 1. employed (part-time, full-time or student); 2. unemployed.
Drug: 1. opiates; 2. alcohol; 3. other drugs.
AA/NA: 1. <10; 2. 11-40; 3. 41-80; 4. >80 meetings attended.
Adult Sexual Assault: 1. present; 2. absent.
Dependent Variable: 1. DO (drop-out); 2. COMP (complete treatment)

APPENDIX F Details of Statistical Analyses: Treatment Outcome

Outcome Six Months Following Treatment

Tables 1 and 2 provide more details of the statistical analyses examining treatment drop-out six months following admission, of the clients of Jarrah House and those of the traditional mixed-sex services.[a]

Data Analysis

The first stage of the data analysis tested for changes between baseline and six-month follow-up using repeated measures analysis of variance on the continuous measures, and chi square tests on categorical variables. Secondly, chi square tests and correlations were applied to test for variables, other than treatment group, that predicted outcome at 6-month follow-up. Finally, the categorical univariate findings that suggested differences between the treatment groups in outcome at six months were submitted to a logistic regression analysis using the LOGIT module of SYSTAT to adjust for possible confounds.

[a] *For further details see Copeland, J., Hall, W., Didcott, P., & Biggs, V. (1993). Comparison of a specialist women's alcohol and other drug service with two traditional mixed-sex services: Client characteristics and treatment outcome. Drug and Alcohol Dependence, (32), 81-92.*

Table F.1

Treatment Outcome of Subjects Interviewed at 6-Month Follow-Up by Type of Treatment

	JH (n = 52)	CS (n = 45)	Odds Ratio	95% Confidence Interval
Used alcohol or other drugs (%)	63	64	0.90	[0.39, 2.08]
Weeks to first use (mean (sd))	1.22 (1.3)	1.00 (1.1)		[-0.29, 0.69]
Client's perception of control over use (%)	56	49	1.54	[0.60, 3.97]
"Risky" behaviour (%)	27	35	0.84	[0.28, 1.59]
Intervening detox. (%)	15	20	0.71	[0.25, 2.01]
Intervening drug-related conviction (%)	8	13	0.83	[0.14, 2.06]
AA/NA attendance (%)	67	62	1.25	[0.54, 2.88]

Table F.2

Percentage of Clients in a Variable Class on Admission that were Engaged in "Risky Behaviour" at 6-Month Follow-Up by Type of Treatment

	JH (n = 52)	CS (n= 45)	Odds Ratio	95% Confidence Interval
Employed (%) on admission	31	24	0.69	[0.21, 2.27]
Dependent children (%)	24	26	1.14	[0.27, 4.79]
No stable (%) relationship	24	39	1.97	[0.76, 5.11]
Maternal history (%)	33	24	0.67	[0.14, 3.17]
Paternal history (%)	12	32	3.38	[0.72, 15.89]
Lesbian (%)	27	67	5.33	[0.34, 82.83]
Prostitution (%)	22	42	2.50	[0.51, 12.35]
Sexually abused in childhood (%)	30	13	0.37	[0.07, 2.01]
Sexually abused in adulthood (%)	19	33	2.20	[0.58, 8.31]