Reaching Women with Drug Histories in Need of Reproductive Health Services

Women who use drugs, or who are involved with partners who use drugs, are at risk of contracting and transmitting sexually transmitted diseases (STD) including HIV. Women with drug histories also have been found to be at risk of unintended pregnancies due to their lack of consistent contraceptive use. Drug use appears to reduce their ability to make judgments associated with taking precautions. For example, one study found that heroin using women were less likely than non-using women to use condoms or any method of contraception (Ralph and Spigner, 1986). In another study of injectable drug users, women who injected drugs more frequently had more sex partners, had sex more frequently, and used condoms less than women who injected drugs less frequently (Schilling, El-Bassel, Gilbert & Schinke, 1991). Of women enrolled in drug treatment programs, women who continued to use drugs were less likely to use reproductive health services than women who reported not using any drugs (Armstrong, Samost & Ben-civengo, 1992). Further, a study of sexually active women and men in drug treatment programs found that few used condoms regularly (Magnus, Shapiro & Siddiqi, 1990; Worth, 1989).

Reproductive health services that include educational counseling, contraceptives for the prevention of unplanned pregnancies and STD/HIV, and medical screenings and treatment, help to reduce risky behaviors. The challenge is to make these services accessible and user friendly for women with drug histories. The Family Planning Council of Southeastern Pennsylvania (Council) developed a study and model intervention project to face this challenge and answer the following questions: Why are women with drug histories inconsistent and infrequent contraceptive users? How important are reproductive health services? What barriers prevent women with drug histories from using these services?

Barriers Associated with Reproductive Health Services

Focus groups and open-ended interviews are successful methodologies for learning about issues, attitudes, perceptions and norms of a particular population, e.g., women with drug histories. In one series of facilitated group discussions, intravenous drug-using women and women with sex partners of bisexual men and intravenous drug users said they rarely used birth control methods (Worth, 1989). Using birth control was not viewed as important because of the high positive value placed on pregnancy. For the women in these groups, pregnancy represented a partner’s commitment to the relationship, and introducing condoms in a long-term relationship often disrupted the trust between partners.

Council staff conducted a series of eight focus groups with female and male drug users as part of the formative research for the intervention project discussed in this article. Similar to Worth’s findings, contraception was reported to be less important than a desire for and the importance of having children. Many of the women had their children taken away when they were active drug users and wanted to have another child (Kenen & Armstrong, 1992). As one woman whose child was living with her expressed “I love being a mother. That’s all I have.” In addition to seeing contraception as conflicting with motherhood, many women in drug treatment programs believed that contraceptives have numerous side effects, interfere with sexual pleasure, are dangerous to
their health, and are ineffective (Armstrong, Kenen & Samost, 1991).

In the focus groups, the condom was the most frequently discussed birth control method. Condoms were known primarily as a way to prevent STDs and HIV. This method, however, was frequently associated with promiscuity and evoked issues of trust between partners. One woman said, "If I find [condoms] on him, I'm going to kill him because he doesn't use them with me." Condoms were generally used with casual partners or with "professional tricks," not with a steady partner.

Other barriers to obtaining reproductive health services included fear of exposing histories of physical and sexual violence, lack of stable housing or homelessness, punitive or impersonal care by health providers, and difficulties in adhering to appointments. Half of the participants from the focus groups in drug treatment programs could not identify what services were provided in family planning clinics and found the term "family planning" ambiguous; they preferred the general term "health care." For those who could identify the services, STD counseling and screening were considered the most important reasons to use reproductive health services. However, the women felt that the timing of using health services was positively related to progress in drug recovery because that is when women often begin to care about their health and experience increased self-esteem.

Two Family Planning Models in Nontraditional Settings

Information from these focus groups was used to modify services in a three-year (1988-1991) demonstration project—Perinatal HIV Reduction and Education Demonstration Project (PHREDA)—conducted by the Family Planning Council and funded by the Centers for Disease Control and Prevention (CDC). PHREDA was designed to increase the accessibility of reproductive health services for women with drug histories and other HIV risk behaviors in order to reduce unintended pregnancies and the perinatal transmission of HIV infection. Placing reproductive health services in the nontraditional setting of drug treatment programs, instead of the traditional hospital or community clinic settings, was expected to increase the accessibility and use of these services. As revealed in the focus groups, women enrolled in drug treatment programs are potentially more receptive than active drug users to reproductive health services. However, prior to PHREDA, contraceptive and reproductive health services were rarely provided in drug treatment settings as their separate funding streams did little to facilitate integration of services.

PHREDA integrated two reproductive health service models into 13 drug treatment programs in Philadelphia. The demonstration programs included methadone maintenance, outpatient drug-free, and residential programs. The first model, a counseling and referral model, included a family planning counselor on-site one-to-two days a week at nine drug treatment programs. The counselor offered individualized gynecological and family planning counseling and education, distribution of nonprescription contraceptives, pregnancy testing, and referrals for other services as needed.

The second model, a counseling and medical model, provided both counseling and comprehensive family planning medical services on-site at four drug treatment programs. A team, made up of a family planning counselor and a mid-level clinician, provided services two days a week. The counselor provided the same services offered in the counseling and referral model, and the mid-level clinician (physician's assistant or nurse practitioner) provided the same family planning medical services as provided in federally funded family planning clinics. These services included gynecological exams; blood pressure and weight assessments; laboratory tests for anemia, diabetes, cervical cancer, and STDs; treatment for STDs; and all available methods of birth control.

Family planning services were free for all women and men in the drug treatment programs and were in accordance with Title X family planning federal guidelines that require services to be confidential and voluntary. Between July 1989 and June 1991, 958 women and 319 men used the services at the 13 drug treatment programs. The family planning staff, employed by the Council, also provided information on sexuality and reproductive issues to the drug treatment staff. Space for the services was provided by the drug treatment programs.

Implementation Challenges

A start-up period of three months was needed to smoothly integrate family planning services into the 13 drug treatment programs. The new partnership required careful and thoughtful negotiations that included defining the limits of responsibilities and developing confidentiality and medical guidelines. Trainers skilled in both sexuality and substance abuse conducted trainings for all drug treatment staff to promote the integration of sexual health and HIV risk reduction into drug and alcohol treatment. Conversely, the family planning staff received training in drug related issues. These trainings fostered opportunities for discussions related to co-locating reproductive health services at the drug treatment settings.

Initially, few women used the reproductive services. Women were reluctant to schedule appointments; when they did, the appointments were usually broken. Women were more comfortable dropping by unscheduled and expecting to be seen immediately. Family planning counselors and clinicians quickly learned that the provision of services in these nontraditional settings would need to differ dramatically from traditional family planning clinics. Therefore, the following changes were made. Open houses with refreshments were scheduled to offer women a chance to meet the service providers and to pick up educational materials. Services were renamed "health care" instead of "family planning." Recruitment became a collaborative effort of the drug treatment counselors and family planning staff. Some drug treatment programs included reproductive health services as part of their routine screening process. At all sites, women were encouraged to stop by for services on an "as needed" basis, and they were not required to have a physical...
EXCELLENCE IN ACTION

Providing Family Planning Services in a Recovery Program for Women

Valerie, a 26-year-old Latina with six children, came to FOCUS to overcome her addiction to heroin. While attending the FOCUS program, she was living at the home of her boyfriend, who became physically abusive to her. She talked to a FOCUS counselor and explained that she was not interested in having any more children, but that her boyfriend forced her to have sex and refused to use a condom. She wondered what she could do.

Mary Ann, an 18-year-old woman, was attending the FOCUS program to stop using crack and marijuana, and attempting to reunify with her 11-month-old baby, who was living in a foster care home. Her medical history included eight abortions and two miscarriages. After six months in recovery, she met a new boyfriend at a clean and sober dance. She was concerned about not getting pregnant again, but did not have any information about her options.

Women who enter FOCUS, an AI/A program in Stockton, California, average 6.6 pregnancies; 47% have had between four and seven pregnancies, and 42% have had eight or more. More than half (58%) of women in the program have more than four children. Fifty-three percent have had at least one miscarriage. Most of the women (84%) have had at least one abortion, and 44% have had two or more.

This data indicates a clear need for family planning services and access to women's health care for women who use drugs and/or alcohol. Often, these women have had poor school attendance, little contact with social service agencies, and lack basic information about family planning and birth control options. The FOCUS program has developed a range of services to ensure that program participants have both the information and assistance they need to obtain family planning services.

The FOCUS Program

FOCUS is a recovery program for pregnant women and women with young children, whose lives have been affected by the use of drugs and alcohol. FOCUS' goals are to help women maintain long-term sobriety, and to help them provide a healthy and nurturing home for themselves and their children. FOCUS strives to achieve these goals by providing a nine-month substance abuse day treatment program with on-site services including drug counseling, educational classes and special counseling groups for women. Topics of classes and groups include: drug education; mother-child bonding; self-esteem and healthy relationships; parenting and family interaction skills; home management; women's and children's health; family nutrition; domestic violence support; and molest survivors support.

Family Planning Services

The FOCUS program also provides women with information and options for family planning in a number of ways. Program staff survey clients about their family planning needs as they enter the program, assist clients with scheduling family planning and health care appointments, and provide transportation to the appointments. Additionally, the program contracts with San Joaquin County Public Health Services to provide a public health nurse on-site 20 hours per week. One of the nurse’s responsibilities is to conduct an individual family planning consultation with every client in the program. During this consultation, the nurse discusses each client’s options and provides information in a confidential manner. The nurse can also review signs and symptoms of STDs and recommend a medical appointment if necessary.

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The FOCUS program also has an interagency collaboration with Planned Parenthood of San Joaquin Valley. As part of this agreement, Planned Parenthood provides a special liaison who prepares FOCUS clients for clinic visits and accompanies them to the clinic. Additionally, the agency conducts a 12-week class on women’s reproductive health at the FOCUS program. The instructor for this course was specially selected by Planned Parenthood for her knowledge of substance abuse and recovery issues. Class topics are as follows:

- **Week 1:** Introduction to Planned Parenthood Classes
- **Week 2:** Sexual and Reproductive Anatomy - knowledge of male and female sexual and reproductive parts and the importance of preventative health care
- **Week 3:** Sexually Transmitted Diseases - symptoms, modes of transmission, consequences and treatment of STDs; information about safer sex practices and prevention
- **Week 4:** Birth Control - contraceptive choices, method use and family planning
- **Week 5:** Sex, Drugs and HIV - HIV/AIDS facts, attitudes, myths, and risk prevention
- **Week 6:** Going to the Family Planning Clinic - education on the processes of a clinic from walking in the door to leaving the clinic
- **Week 7:** Decision Making - decision making skills and defining personal values
- **Week 8:** Self-esteem - defining and setting boundaries; being in charge of your own body and mind
- **Week 9:** Relationships - defining and evaluating positive and negative relationships
- **Week 10:** Communication - exploring and promoting positive forms of communication with partners
- **Week 11:** Safer Sex and Condoms – how to use condoms; talking openly about safer sex
- **Week 12:** Evaluation

Finally, in an attempt to increase the accessibility of family planning services to FOCUS clients, the program established an on-site women’s health clinic scheduled to open in April 1996. The program began planning for an on-site clinic when it relocated to a larger space in 1995. The clinic will be operated collaboratively with San Joaquin County Health Care Services. It will be open two days a week, and will offer prenatal and postpartum care, as well as family planning services.

**Conclusion**

Because of barriers to education about family planning and access to health care, many women at risk of substance abuse do not use family planning services. In order to help women make informed decisions about contraception and family planning, treatment programs need to provide a wide range of accessible and appropriate services to meet the needs of this diverse and high-risk population.

The FOCUS program hopes that its services will help women avoid unplanned pregnancies and reduce the high rate of children born exposed to drugs and alcohol. Most of the clients in the program have taken advantage of the family planning services available, and all of them have better information to help them make critical decisions for their future and their families.

— Frances Hutchins
Director, FOCUS

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**Innovations in Family Planning with Women Affected by Alcohol and Other Drugs**

The National Abandoned Infants Assistance (AIA) Resource Center recently initiated a Technical Expert Group (TEG) to explore issues related to family planning with women affected by alcohol and other drugs. Specifically, this group will be studying effective education and counseling strategies, as well as intervention and referral techniques, to help pregnant and parenting substance abusers make informed, responsible decisions about contraception and family planning. The Resource Center is soliciting any information that would contribute to this effort. They are especially interested in strategies for assessing family planning issues in child welfare or family support programs.

Please direct any information or questions to Caroline Haskell, MS, at 913 Laurie Circle, Pacific Grove, CA 93950, or 408/646-8377.
Coming Up Pregnant: Cultural and Spiritual Issues in Family Planning

Over two-thirds of women served by AlA programs are African American or Hispanic (Barth et al., 1995). The majority are affected by substance abuse, are poor, and have chaotic living situations and little family or community support. This article highlights some of the spiritual and cultural issues involved in family planning among this population, while acknowledging that culture and spirituality are heterogeneous and not the only motivators for human behavior. The article also suggests some basic, general counseling strategies which are empowering and support a woman’s right of choice.

Cultural Issues

African-American women in this country have long felt their fertility subject to control and public scrutiny. Black women slaves were often prized for their fertility—for their status as “breeders.” More recently, Black women on welfare have been demonized in the public arena as contributors to the country’s general moral decline and parasites living off the sweat of honest working people. Some in the Black community feel that there is a genocidal war being waged against African-Americans. They believe that: AIDS is a man-made virus being used for germ warfare, drugs such as crack have been introduced deliberately to undermine the community, and family planning is targeted at decreasing the number of Blacks. Those in the Black community who do not necessarily subscribe to these beliefs feel that some level of paranoia about the motives of the “establishment” (e.g., government, healthcare providers) is healthy, considering a long history of oppression.

Traditionally, Black religious leaders have preached a code of behavior which emphasizes sexual continence, abstinence before marriage and adherence to family values. Contraception is sometimes seen as encouraging promiscuous sexual behavior; abortion is frowned upon or openly condemned. Some Black religious leaders have been the strongest opponents of sex education and condom distribution in schools and were very vocal critics of the former surgeon general Dr. Jocelyn Elders. The Reverend Calvin Butts, pastor of the Abyssinian Baptist Church in Harlem and a well respected civil rights leader, was quoted in a recent article that he has “mixed views on contraception” (Meskil, 1995). Among his concerns were the sexual activity of teenagers before marriage and its potentially deleterious effects on health.

In some inner city neighborhoods, the Black male’s ability to support and maintain his family has been eroded by epidemics of violence, substance abuse, and high rates of unemployment. Studies of urban areas have estimated that 30% to 60% of young Black males have some involvement in the criminal justice system (Mincy, 1994). As marriage or another permanent relationship with a Black man ceases to be a viable option for some inner city women, many couples consciously or unconsciously choose to have children in order to give their relationship a form of permanency.

Many inner city neighborhoods have also experienced an influx of immigrants from Spanish speaking countries, e.g., El Salvador, Mexico, and Honduras, along with Puerto Ricans who continue to move to the “mainland” to seek a better life. Women from these and other diverse Spanish speaking countries have been categorized as Hispanic, a term created by the U.S. Census Bureau in 1978. Whether there is such a thing as a “Hispanic” or “Latino” culture is hotly debated. Most of these countries share a similar colonial experience with Spaniards, but vary in the mix of Indian, Black, European, and American influence. Nevertheless, a long history of oppression has left many Hispanic women illiterate, poor, and with limited economic opportunities.

Hispanic culture dictates that a woman’s sexuality is the concern of her entire family, respect for authority is prized. Most Hispanics are Catholics or evangelical Christians. Abortion is seen as murder by the Roman Catholic Church, yet contraception is not condoned. Hispanic women in New York have one of the lowest rates of abortion, having fewer than 5 abortions per live birth (Meskil, 1995). Although attitudes are changing, discussion of sexual subjects has often been considered taboo, even between mother and daughter. Traditionally, for Hispanic women, the means to economic stability has been through their relationships with men.

Continued on next page...
Substance Abuse Subculture

With the introduction of crack cocaine into already stressed inner city neighborhoods, many women who previously were able to hold their families together, have become substance abusers. Substance abusers form their own subculture whose norms support continued drug use. The addict loses the ability to formulate meaningful plans and goals, including family planning. Pressure to obtain drugs in order to reduce the physiological and psychological tension produced by the absence of drugs in the body is great and soon becomes the main focus of the drug abuser. Often, crack addicted women trade sex for drugs, and they typically have low rates of contraception usage. In some circumstances, addicts are able to achieve a certain stability—sometimes known as a “functioning addict.” Typically, however, substance abusing women are not open to intervention and family planning counseling until they begin the recovery process.

Family Planning Counseling

Women served by AIA programs have complex cultural backgrounds and spiritual beliefs, and varied needs which are challenging to meet. Empowerment is the “ghost in the machine” of our work with them, and we must look carefully at how we measure their success. Often we approach clients with our own agenda; when they don’t buy into it, we feel angry and helpless. Helpless statements by program staff include: “Why does she keep having all these children?” “Somebody should lock these women up.”

Clients feel disempowered too: “I guess I’m just fertile.” “My mother says I’m a breeder.” “I don’t know why. I just keep coming up pregnant.” “I don’t like needles, the pill makes you fat, my man doesn’t like condoms and the IUD is no good for you. Right now I’m not using anything anyway because I’m not having sex.” “My mother wants me to get my tubes tied but I’m too young.” All these quotes from clients that I and others have worked with reflect lack of knowledge, denial, and disengagement from any sense of control over one’s own life and ability to produce or not produce children.

It is helpful to understand that family planning is a process, not a one time event (unless a woman chooses sterilization). In order to practice family planning successfully, a woman must first visit her doctor, be receptive to information about the various methods and then choose and use one. She must return for medical evaluation and, if she has a problem with side effects, discuss these with her practitioner and negotiate a solution—either to learn ways of coping with side effects or to change the method. Depending on the method chosen, she may have to negotiate with her partner and obtain his cooperation.

Processes like this are difficult to complete for women who are engaged in substance abuse, lack access to medical care, and have difficulty negotiating rights and boundaries with healthcare providers, lovers, etc. At every step in the family planning process, a breakdown can occur which can cause a woman to stop practicing birth control. She may miss appointments, not discuss her concerns with her healthcare practitioner, not understand the information given to her, become concerned about side effects, or have her efforts sabotaged by her partner. Additionally, birth control may be a financial hardship for a woman without insurance.

Program staff can help their clients negotiate this process by: working with local health care providers to free up slots for clients; inviting family planning experts to educate staff and clients on available methods; offering classes on basic female anatomy and hygiene; or providing transportation. In addition to this kind of support, counseling which focuses on issues of self-esteem and assertiveness is important. American culture and economic realities dictate that a small family size is optimal for a child to thrive and reach his or her potential, and most women desire control over their family size and spacing. Our clients realize, on some level, that by continually having children, they are stressing their family’s psychological, economic and social resources to the maximum; but many of them have lost or given up their control in the face of competing pressures (e.g., cultural norms which support childbirth and continued reliance on relationships with men; intrapsychic needs for love and belonging; the constant pressure to support an addiction).

In the absence of this control, being pregnant becomes a powerful source of self-esteem for some women. Pregnant women get cultural support and recognition. People give up seats on the bus for them, strike up conversations with them, encourage them to eat and take care of themselves, and give them baby showers. In order to help women learn how to gain or regain control over their own reproductive systems and make decisions about their family planning, we must recognize and work within the unique cultural beliefs that guide their actions and decisions. Self-esteem lost through drug abuse can be rebuilt as a woman begins to master the necessary steps to recovery. The therapeutic relationship between a client and counselor plays a critical role in this process. Program staff who engage clients in relationships with trust and honesty, which honor their cultural values and norms, can help clients perceive another reality—a reality in which women don’t just “come up pregnant.”

— Alexis Sackor, RN, MPH
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Acknowledgment and thanks to Jill Sofia, R.N., for her helpful insights.

REFERENCES
Reproductive Health Education: A Priority Training Topic For Professionals Working with Recovering Women

This article outlines a training curriculum for substance abuse counselors, which utilizes public health education strategies in a relapse prevention framework. The curriculum includes health education and ways to identify strengths of women and their families as integral components of relapse prevention. It is based on the belief that health education and discussion about reproductive health issues can emerge naturally when women in recovery are in a safe environment revealing their inner struggles and identifying triggers to relapse.

Relapse Prevention

Addiction is a multi-pronged disease which damages the mind and body with the craving for drugs or alcohol. Controlling the urge to use drugs and alcohol, which is often a physiological and psychological pattern of behavior, requires tremendous effort. Therefore, relapse prevention strategies must address a multitude of emotions and urges within each woman.

In substance abuse treatment programs, relapse prevention emphasizes self-identification of triggers for substance use and control of the urge to use. Triggers are generally people, places or things (PPT) which produce a nostalgic attitude toward the effect of drugs and alcohol, or extreme feelings of anxiety, fear or anger which a woman wants to obliterate with drugs and alcohol as she has in the past. In the prevention of relapse to drug and alcohol use, women are encouraged to avoid PPTs self-identified as triggers, or to create ways to relieve the stress and other strong feelings. Each woman’s way to relief is unique. Women may find release in a treatment group or a 12 Step meeting; in a talk with their sponsor or a peer; by exercising or reading; by helping children with homework or a game; or through many other activities. Often, the result is a behavioral change in a woman’s reaction to her internal feelings, PPTs, or external pressure.

The risk of relapse in women, however, is often exacerbated by stressful life events related to her or her family’s reproductive health. For example, a history of sexual abuse, the prospect of sober sex, other reproductive health concerns (e.g., hysterectomy), a personal HIV/AIDS diagnosis, or an AIDS death of a family member or a peer during a woman’s recovery journey, may overwhelm a woman’s coping skills. In these

Shared Family Care Program Guidelines

The National AIA Resource Center is pleased to announce a new publication, Shared Family Care Program Guidelines. Shared Family Care (SFC) refers to a situation in which an entire family is temporarily placed in the home of a host family who is trained to mentor and support the biological parents as they develop skills and supports necessary for care of their children and move toward independent living. SFC can be used for prevention—making it unnecessary to separate a parent(s) from her or his child, or for reunification—providing a safe environment in which to reunite a family that has been separated.

The Shared Family Care Program Guidelines were developed by the National Abandoned Infants Assistance (AIA) Resource Center and a national group of experts. The Guidelines are designed to educate agency administrators, program managers, policy makers and funders about the potential uses of shared family care, and to identify the steps and information needed to develop and implement this service.

The Shared Family Care Program Guidelines can be purchased from the AIA Resource Center for $15.00. The Guidelines are also available for loan through the AIA Lending Library. To order a copy or request additional information, please contact:

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The public health field advocates for behavioral change, as advocated by Ginosky and Freire (Gorski, 1989; Freire, 1970), is a belief in the existence of an inner strength to change certain behaviors within individuals, families and communities. Belief in individual strength and human resiliency is part of the framework for incorporating reproductive health education into substance abuse treatment programs for women.

The emergence of AIDS as one of the leading causes of death for all women 25-44 in the U.S. (Selik, Chu & Buehler, 1993), and the alarming number of women becoming infected with HIV through heterosexual sex and intravenous drug use, has increased awareness among health and social services providers. As a result, HIV/AIDS prevention education has made an appearance in most substance abuse treatment programs for women. The most popular slant has been to provide HIV prevention education in relation to future sexual practices. The connections, however, were not being made between a woman's sexual practices and her decisions about if and when to conceive.

Similarly, although female treatment programs have begun to recognize the critical role of male partners in women's recovery, they are just beginning to include men in the treatment process. Many programs are addressing issues such as living arrangements, emotional boundaries and childcare responsibilities, however the topics of sex and HIV prevention typically are broached on a broader educational level, rather than a personal level with the woman and her partner. Discussions of these issues, as well as sexual assault and childhood incest, help breakdown the barriers of isolation, lessen a woman's denial and shame, and help her progress in her recovery. Yet, substance abuse counselors often are unsure how to address these issues in a woman’s treatment program. In order to make these connections and provide HIV and reproductive health education within treatment programs, treatment staff require support and training around these issues.

**Health Education in Treatment Programs**

Training on reproductive health issues can be incorporated into existing staff development programs using local resources, or by creating a separate training program. Local Planned Parenthood agencies or community health clinics, which generally provide comprehensive family planning counseling and reproductive health services, can be a tremendous resource for substance abuse counselors. Coordinating with reproductive health staff affords the treatment staff informal consultation, while treatment staff can also advise reproductive health staff about possible strategies for working with substance women. This collaboration serves to decrease the isolation felt by providers, and to increase the sensitive and comprehensive treatment and reproductive health services available for women substance abusers.

Before establishing a formal training structure for treatment providers, however, the barriers to instituting family planning services at a women’s treatment program, and strategies for overcoming these barriers, must be thoroughly explored. Motherhood, fertility, sexuality, family size, contraception, and reproductive choices are emotionally charged issues, especially for female addicts. As we see in our daily lives, female addicts who are mothers are still vilified on television, in the print media and in general conversations, almost ten years after the “crack baby” media hysteria. Also, religious beliefs ranging from “each child is a gift from the Creator” to “contraception is a sin” play a critical role in reproductive health education. Parents with strong religious beliefs may be hesitant to voice anger, fear, or anxiety about the stress of adding another child to their family.

Additionally, many staff in women’s treatment programs are in recovery themselves and may deny personal risky behavior. Denial of risky behavior in a staff’s history of alcoholism or addiction may be another barrier to working through these same issues with women in early recovery. Treatment staff also can be protective of a woman’s commitment to recovery, and reluctant to address any additional issues (e.g., sexual abuse, sober sex, HIV prevention) which may create added stress.

A training model that elicits these fears, attitudes and concerns, and deals with them in an honest and forthright manner, allows for the eventual development of guidelines for comprehensive and compassionate reproductive health education in treatment programs. A self assessment exercise during a staff meeting could introduce these issues and begin to identify each staff’s motivation and/or barriers. The therapeutic skills necessary to make the connections between healthy sexual behaviors and recovery are generally employed by treatment staff for stress reduction and relapse prevention. Self awareness, identification of stressors, recreational activities, routines, forgiveness and behavior change are all transferable skills to reproductive health education.

Training exercises that role play different clients with different views can be very helpful to staff in delineating creative support for each specific woman. Non-judgmental listening and meeting the client where she may be are the foundations for effective counseling, yet staff
Addressing the Reproductive Health Concerns of Alcohol and Drug Dependent Women: A Challenge for Family Planning Clinicians

Alcohol and drug use is often associated with behavior that leaves women at risk for HIV/AIDS, other sexually transmitted diseases, and unwanted pregnancy (Mondanaro, 1989; DHHS, 1994). Women who use alcohol and other drugs often have difficulty with compliance in using birth control. Also, women in recovery from alcohol and drug use typically have barriers to accessing and using family planning services.

Health professionals are often frustrated by the denial of alcohol and drug abusing clients and feel at a loss in addressing the multiple needs that these women bring to the health care setting. Because of the harsh stigma attached to female alcoholics and addicts, professional caregivers may be inclined to focus on secondary problems rather than alcohol or drug-related issues (Bell Unger, 1988). On the other hand, a sensitive and knowledgeable health care provider can provide assessment, intervention and referral services that may positively impact a woman’s health and, potentially, help transform her life. The tools to effectively serve this population include: (1) a framework for understanding the correlations and dynamics associated with alcohol and drug problems among women; (2) an understanding of the role of the family planning clinician in addressing alcohol and drug issues; and (3) continued development of skills for working with alcohol and drug dependent women.

Factors Impacting the Provision of Family Planning Services for Alcohol and Drug Dependent Women

Many of the physical, psychological and social correlates and consequences of alcohol and drug use impact women differently than men. These differences have significant implications for the various kinds of assistance that women need in the process of accessing and utilizing health care services of all kinds. For example, women are more vulnerable than men to the physiological consequences of alcohol or drug abuse (e.g., more likely than men to develop liver disease even with less alcohol consumption). A prescription for birth control pills may carry potential hazards for a recovering woman who has liver disease secondary to excessive alcohol use (Mondanaro, 1981). Family planning practitioners will need to consider the impact of these physiological issues when providing counseling about birth control.

Psychological and social factors must also be considered when providing services. Alcohol and drug dependent women suffer more depression and have lower self-esteem than men with similar problems or women in general (Beckman et al, 1980; Braiker, 1984; Roman, 1988). A significant number of alcohol and drug dependent women (34% to 75%) are survivors of childhood sexual abuse (Wilsnack, 1991). The fact that motherhood is often perceived as the only socially acceptable role that might mitigate feelings of low self-esteem can be a disincentive to considering or using birth control for many alcohol or drug dependent women (American Health Consultants, 1991). Many populations of women have historically been targeted for forced sterilization and may perceive family planning as a threat rather than an opportunity to take control of their reproductive choices (e.g., if and when to have children).

Unfortunately, many alcohol and drug dependent women have had prior negative experiences with helping professionals or representatives from social service delivery systems. Any or all of these issues may impact how safe, accessible and acceptable family planning services are experienced by an individual woman.

Family planning services that are grounded in knowledge about alcohol and drug problems in women, and sensitive to the histories of women seeking help, can be of tremendous benefit to a population of women who have traditionally felt disempowered in relation to their physical, emotional and social health.

Role of the Family Planning Clinician

Family planning clinicians are committed to addressing a broad range of health and lifestyle issues that impact a woman’s reproductive health and her capacity to make health choices. Issues related to alcohol and other drug dependencies clearly impact the general and reproductive health of women. The role of family planning clinicians related to alcohol and drug issues include the following:

- Screening: Family planning clinicians can provide invaluable services to their clients by integrating simple screening tools into their health assessments. Many programs use the “4 P’s” or the CAGE models for this purpose. The 4 P’s comprise a first level screening tool designed to identify patients that may benefit from further assessment, education and possible referral. Patients are asked if they have: (1) a parent alcoholic or addict; (2) a partner with a problem; (3) past problem with drugs or alcohol; and/or (4) a present problem with drugs or alcohol. The CAGE has been used as an efficient screen for alcoholism where early intervention can help arrest the progression of the disease. The CAGE questions ask if an individual has: (1) ever felt they should Cut down on their drinking; (2) been Annoyed with other people criticizing their drinking; (3) ever felt Guilty about drinking; or (4)
ever taken an Eye-opener (a drink in the morning) to steady their nerves or get rid of a hangover.

Education: Many alcohol and drug dependent women (including women in recovery) have no information or misinformation about their sexual health. For example, some women with alcohol and drug problems make choices based on the erroneous assumption that drug or alcohol induced menstrual irregularity means that they cannot get pregnant. Family planning services, for some women, is the only entry point for health and other services and their primary source for health information.

Referral: Family planning clinicians do not need to be alcohol and drug counselors, but they need to know where and who the counselors are. This includes having referral information about local programs, self-help groups and other related resources to provide for clients who may be interested. It is helpful to have information about the structure of the program, what to expect from a program and the names of contact persons. Regardless of the outcome, discussing options related to recovery and other self-care choices is of value. A clinician cannot force a positive outcome; however such an expression of concern may plant a seed that may bloom in the future.

Collaborator/Ally to treatment programs: In addition to having information about programs, developing tangible linkages and creative collaborative efforts with alcohol and drug programs serving women can be advantageous to the staff and clients of both service delivery systems. The California Department of Health Services, Office of Family Planning, recognizing the importance of providing services to this high risk population of women, has funded five pilot Chemically Dependent Women Family Planning Projects that provide collaborative services for women in early recovery. Even without special funding, local Family Planning and Alcohol/Drug Programs can create access to services for clients with dual needs, share information that may be of use to one another’s clients, and strengthen the skills of both service delivery personnel through periodic cross trainings.

Implications for Family Planning Staff

In conclusion, brief descriptions of a few specific guidelines for approaching and working with alcohol and drug dependent women are outlined below.

Knowledge about the disease model of recovery is often helpful in framing and discussing possible alcohol and drug problems. It helps to free women from unproductive shame and self-blame. No one elects to become an alcoholic or addict; she is not responsible for her “disease,” but she is responsible for and capable of seeking recovery. Continued training and exposure to the alcohol and drug field may help family planning clinicians to build both intervention skills and empathy.

An accepting, non-judgmental attitude is most effective. Women with current or former alcohol/other drug problems are sensitive to and all too familiar with criticism and disapproval from health care professionals. An open and non-judgmental attitude is more likely to create a path through well established denial and defensiveness. Communicating honestly, listening, setting limits as needed, and offering support can go a long way toward building trust.

Making alcohol and drug issues “discussable” is key. Integrating alcohol and drug content into questions and screening is an important beginning. Also, integrating non-judgmental and informative overview information for all clients may open a door for a client/patient concerned with alcohol and other drug issues. Remember, it is often not that easy to recognize who may have alcohol or drug problems.

Conveying a sense of hope may make recovery seem attainable. Being “armed” with stories of the struggles and successes of others can be useful. Clinicians do not have to be former alcoholics or addicts to carry the message that recovery is possible.

Clinicians must be aware of their own attitudes, values and potential for professional enabling. All helping professionals, as people, have their own experiences, opinions, and values related to alcohol and drug issues. Self awareness is critical to overcoming barriers to work with women who have or who are recovering from alcohol and other drug problems. In an effort to avoid discomfort, even the most skilled professional can be at risk for enabling behaviors including minimizing, rationalizing, denial and avoidance. It can be difficult to broach this subject, especially when a patient or client may respond with anger. In another vein, helping professionals may feel overly responsible for all aspects of a client’s recovery rather than being responsible to the client in providing appropriate assessment, intervention and referral services for the client use.

Self-care for caregivers is critical. There is great value and inspiration in helping others to help themselves. At the same time, clinicians are most effective when they remember to take care of themselves. Self-care includes obtaining the support of peers and colleagues in nearby alcohol/drug programs in dealing with difficult clients, identifying safe places to express feelings and frustrations, and enjoying nurturing relationships and activities outside of work.

—Laurie Drabble, MSW, CADC

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Examination in order to receive counseling. Family planning counselors needed to be prepared to assist with barriers such as sexual abuse or housing emergencies before reproductive health care needs could be addressed. With these changes, and through word of mouth, more women began to use the on-site services.

Evaluation of the Two Intervention Models

To assess the two models, 599 nonpregnant and nonmenopausal women from the 13 drug treatment programs were enrolled in a longitudinal study. In-depth interviews were conducted before using on-site family planning services, and again 9 and 15 months later. Information was collected on demographics, past and present drug use, sexual behaviors, pregnancy history, past and current contraceptive use, STD history including HIV status, HIV and contraceptive knowledge, and family planning visits.

The ages of the women ranged from 16 to 56 with a mean of 33 years. Most (58%) had completed high school, only 14% were married and 17% were working. For one-out-of-four women, illegal activities were self-reported to be their major source of income. Although enrolled in a drug treatment program, many women reported that they continued to inject drugs (34%), use crack (16%) or cocaine (6%) and to share their needles or works with partners (8%). Based on their interviews, most women were not using condoms (76%), and in the prior 6-month period, 6% of the women had syphilis, 5% had gonorrhea, and 6% had pelvic inflammatory disease.

Of the 599 women, 86% were interviewed 9 months later and 80% were interviewed 15 months later. Between baseline and 15 months, 77% of the women had used family planning services either on site or at traditional locations. Of those using the services at the drug treatment program, 85% were very satisfied and 14% were somewhat satisfied with the service. About half of the women went for a routine exam, one in five went for a specific health problem and fewer (11%) went primarily to obtain contraceptives.

When comparing characteristics of women who did and did not use family planning services, no differences were found in education, marital status, pregnancy or live birth history, sexual activity in the four weeks prior to the baseline interview, or sterilization status. Older women, white women, women whose last pregnancy was unplanned and women who had injected drugs in the last four weeks were less likely to use family planning services. In contrast, those women who had ever used family planning services in the past, wanted another child, had used condoms in the past, or reported ever having had an STD were more likely to use family planning services.

The type of family planning model—counseling and referral or counseling and medical—was not related to use of contraceptives in general, or to the use of condoms in the past four weeks. Younger women were twice as likely to use contraceptives, and those who had previously used family planning services were four times as likely to use contraceptives. Nonsterilized women and women who had more than one sex partner were almost eight times more likely to use contraceptives.

Implications and A New Initiative

This project demonstrated that two distinct funding streams (family planning and drug treatment) with separate administrative systems can be linked to provide needed services to women who engage in high-risk behaviors. Women with chemical addiction histories who start to care about themselves and their health by enrolling in treatment have the opportunity to access needed family planning services on-site. While some women will not be ready to contemplate using these services, others will. Although these services will not guarantee that women will use contraceptives consistently for pregnancy or disease prevention, the use of services is a step toward better health care and increasing contraceptive use.

A subsequent five-year (1991-1997) demonstration research grant from CDC allowed for the expansion of a reproductive health service intervention for women in five drug treatment programs, three homeless shelters and two public housing developments. The goal of this multi-site longitudinal project (Project CARES) is to prevent unplanned pregnancies by increasing contraceptive (and condom) use and to increase use of reproductive health services among women at risk of HIV infection and transmission. In Philadelphia, 1,280 women were enrolled at ten sites and will be followed for an 18 month period. Full counseling and medical reproductive health services are available at all ten sites. Additionally, half of the sites were randomly selected as enhanced sites which have peer counselors (care advocates) who received extensive training in the Transtheoretical Model of Change (Prochaska, DiClemente & Norcross, 1992). These care advocates identify a woman's readiness to change, provide support and referrals for other social and health needs, and provide individual stage-based counseling and group activities (Cabral et al., 1996). In addition, they use a structured manual, designed for Project CARES, as a guide in determining appropriate activities based on a woman's readiness to change. Sites with the enhanced intervention are being compared.
to those without it, and preliminary results of this enhanced stage-based counseling by paraprofessionals are encouraging.

Conclusion

We saw in the first demonstration project that offering reproductive health services in nontraditional settings increased the likelihood that some women will use reproductive services and will increase their use of condoms. However, other women were not yet ready to make these changes. In the second project, the stage based change model encourages incremental changes. For example, one woman changed from not thinking at all about using reproductive health services to now considering and planning to go for these services in the next six months. Another woman changed from using contraception occasionally to using contraception every time she has sex.

Meeting the reproductive health needs of individuals at risk for unintended pregnancies and STD/HIV, including those with drug addiction histories, requires different approaches such as placing the services in nontraditional settings. Linking family planning services with the drug treatment system or other systems (e.g., public housing developments or homeless shelters) requires careful planning, flexibility, cooperation, and resources. Further, the programs need to be theoretically sound and based on interventions with demonstrated effectiveness. Because women with drug related risks comprise a diverse group, an assessment of the intervention should be built into each project in order to identify what works and what does not in each community. Finally, no intervention should be implemented without asking and listening to the women for whom the reproductive health services are targeted.

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may not see the connection to other issues in the women's lives besides those relating directly to her drug addiction. Training can help counselors see that the healing and reclaiming of a woman's body, as well as her mind, her life and her family, is a vital part of recovery.

**Reproductive Health Education as Relapse Prevention With Recovering Women: A Train-the-Trainer Curriculum**

The following curriculum was created to guide treatment staff to use their existing skills to incorporate women's health education into the relapse prevention component of treatment programs. It suggests the inclusion of health issues in a woman's treatment plan and in her daily goal statements as an easy way to integrate health issues into the treatment schedule.

**A. Reproductive Systems Education**
1. Include details about the impact of addiction on fertility, menstrual cycle and sperm (may also include liver, hair, teeth, etc.)
2. Where else can women and men get this kind of information? OB/GYN, Planned Parenthood, health clinic, local library, national clearinghouses

**B. Human Sexuality**
1. Developmental stages (“normal behaviors,” age ranges, etc.)
2. Heterosexual, Homosexual, Transsexual, Bisexual
3. Self-esteem
4. Healing and reclaiming her body: a part of recovery
5. Sexual violence (estimated 75% of women in treatment have experienced sexual assault)

**C. Sex and Motherhood**
1. Definitions of motherhood and family
2. Discussion of family planning beliefs and attitudes
3. Historical abuse of sterilization and fears of genocide
4. Spectrum of contraceptive choices available to men and women
5. Acknowledging possible hidden triggers for women in recovery
6. HIV/AIDS and STDs prevention, protection, and risk reduction
7. Community resources and free materials

**D. Parallels to Recovery**
1. Self-body knowledge
2. Responsibility and protection of one's own life
3. Incest survivors group
4. Sexual violence survivors group
5. Healing and reclaiming her body
6. Self-medication of pain and memories
7. Dispelling the myths of victimhood, fault, no recovery, isolation
8. Denial, guilt, rage . . .
9. Learning new coping skills
10. Doubting sanity
11. Identifying inner strengths of women (i.e., resiliency)
12. Male/female partners

**E. Connections to Relapse**
1. Inter-generational use and abuse of drugs and alcohol
2. How to cope with INCEST without drugs and alcohol
3. Trading sex for drugs/money
4. Possible triggers found in contraceptive devices (e.g., some creams may have an ingredient similar to cocaine that can produce an effect in the vagina reminiscent of cocaine, and the plungers that accompany gels/foams closely resemble IV needles)
5. Male/female partners

*Continued on next page...*
F. Potential Barriers to implementing sexual health education in treatment programs
   1. Religious beliefs
   2. Self-esteem
   3. Who will do it (e.g., talk about sex)?
   4. Denial of risky behavior during staff person's personal history of addiction/alcoholism

Conclusion

Experience has shown that a women's potential risk of relapse appears to be highly correlated with a history of sexual abuse, sex and sobriety, other reproductive health concerns (e.g., hysterectomy, pregnancy), HIV/AIDS diagnosis or AIDS death of family member or peer. As potential sources of stress, these issues must be addressed in order to help a woman overcome her addiction. The curriculum outlined above can be used to strengthen treatment providers' skills in order to help them make the natural connection between health education and relapse prevention. Additionally, outside agencies (e.g., local rape crisis center, Planned Parenthood and HIV/AIDS organizations) can be invited to co-facilitate treatment groups to further address issues related to a woman's reproductive health. In drug treatment, it is crucial to raise difficult issues, especially when a woman's and her family's well-being are at risk. Family planning is one of these issues.

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Upcoming AIA Telephone Seminar

- WEDNESDAY, JULY 24, 1996, 2:00 PM - 3:30 PM (Eastern Standard Time)
- Working with Women Affected by Substance Abuse and Domestic Violence — Carey Tradewell, MS, CADC III, President and CEO, Milwaukee Women’s Center, Inc.

Participants will learn the importance and “how tos” of screening and assessing chemically dependent women for family violence. Ms. Tradewell will discuss safety plans as well as “solution focused” case management and counseling strategies for helping women break the cycle of family violence.

TELEPHONE SEMINAR REGISTRATION FORM

The seminar will be conducted through a teleconference call, at no cost to the participant, and will be limited to 25 sites on a first-come, first-served basis. To register, please complete this form and mail/fax it ASAP to the AIA Resource Center, 1950 Addison Street, Suite 104, Berkeley, CA 94707-1182, ATTN: Teleconferences, Fax: 510/643-7019. For further information, please call the AIA Resource Center at 510/643-8390.

Name & Title: ____________________________________________________________

Agency: ________________________________________________________________

Address: ______________________________________________________________

City, State & Zip: _________________________________________________________

Phone: __________________________ Fax: ________________________________

You will receive confirmation of your registration, and additional information prior to the seminar.
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