Nevada Substance Abuse Treatment Providers – Assessing the Needs and Characteristics of Female Clients in Recovery

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EXECUTIVE SUMMARY

The University of Nevada Cooperative Extension (UNCE) conducted a needs assessment to determine the needs of female substance abusers seeking treatment in Nevada as many women in treatment often lack basic health skills that may hinder their recovery process. A link to the survey was mailed to all licensed substance abuse treatment facilities in Nevada (n=64) and sent by electronic mail to providers in Nevada (n=60) familiar with the Healthy Steps to Freedom program (HSF) (i.e., they were currently offering the HSF program at their facility or had previously expressed interest in the program). Social media was also used to attract participants – a link to the survey was posted on the Facebook page of UNCE’s HSF program. The survey was designed to collect information on the need of a health and body image curriculum for women as a viable option to augment traditional treatment in substance abuse and mental health recovery settings. The survey contained questions on the following areas:

1) Respondent demographics (i.e., age, education, gender, certifications, etc.);

2) Demographics of female clients the respondents work with (i.e., substances used, weight or weight-related issues, eating pathology, energy issues and mental health); and

3) Need for health and body image programming in recovery.

Results: Of the 124 letters and emails sent out, a total of 46 surveys were completed. The overall return rate was 37% (n=46/124). Although it is impossible to know how many people viewed the Facebook posting, three individuals learned of the survey through this method.

Respondents: The majority of respondents were Caucasian females. More than half (54%) were counselors and about a quarter (22%) were administrators (supervisors and directors). Refer to Table 2 for additional respondent demographics.

Female Client Needs: There was overwhelming evidence to support implementation of a health and body image curriculum into existing recovery treatment. Refer to key findings on the next page.
Key Findings from this Project:

Of Nevada Substance Abuse and Mental Health Treatment Providers:

Prevalence of Stimulant Use in Recovery

- 96% report their female clients are currently in treatment for abuse of illegal stimulant-type drugs (methamphetamine, crack or cocaine, ecstasy, etc.).
- 89% report their female clients utilize (or have used in the past) over-the-counter stimulant-type products (energy pills, weight loss pills, energy drinks, etc.).

Weight Gain in Recovery

- 94% report their female clients have disclosed weight gain since they began their recovery process (or stopped using their drug of choice).
- 84% report that for their female clients who have disclosed weight gain in recovery, this weight gain has negatively affected their self-esteem or self-image.

Use of Stimulants for Weight Loss and Energy Needs

- 91% report their female clients disclosed using stimulants for weight loss (e.g., methamphetamine, cocaine, diet products, energy pills, etc.).
- 84% report their female clients disclosed using stimulants to gain energy (e.g., methamphetamine, cocaine, diet products, energy pills, etc.).

Health and Body Image Programming Need

- 93% agree that a health and body image program would benefit female clients at their facility.
- 92% agree that female clients would be interested in a health and body image class at their facility.
- 80% report only some or none of their female clients have adequate knowledge of how nutrition and physical activity can affect weight change.
BACKGROUND

Throughout the United States, substance abuse continues to be a burden from small towns to major metropolitan cities. Many people do not understand why or how others become addicted to drugs. Drug addiction is a complex disease, and quitting takes more than good intentions or a strong will. Addiction has negative consequences for individuals and for our society as a whole. Estimates of the total overall costs of substance abuse in the United States, including productivity and health- and crime-related costs, exceed $600 billion annually. As staggering as these numbers are, they do not fully describe the breadth of destructive public health and safety implications of drug abuse and addiction, such as family disintegration, loss of employment, failure in school, domestic violence, and child abuse (NIDA, 2011).

According to one study performed by the Pew Research Center’s Economic Mobility Project, one in every 28 children in America has a parent incarcerated (Pew Charitable Trusts, 2010). The number of children with a mother in prison has more than doubled since 1991 (Annie E. Casey Foundation (AECF), 2011). Women under correctional supervision are mothers of approximately 1.3 million minor children who are seven times more likely to be incarcerated themselves (USDOJ, 2000).

DRUG USE IN NEVADA

The Substance Abuse and Mental Health Service Administration’s (SAMHSA) National Survey on Drug Use and Health provides national and state-level data on the use of tobacco, alcohol, illicit drugs (including non-medical use of prescription drugs), and mental health in the United States. In the most recent survey, 9.4 percent of Nevada residents reported using illicit drugs within the past month. The national average was 8.0 percent. Nevada’s rate was one of the 10 highest among all states. Additionally, 4.5 percent of Nevada residents reported using an illicit drug other than marijuana within the past month (the national average was 3.6 percent) (SAMHSA, 2010).
Nevada primary treatment admissions: Table 1 depicts substance abuse primary treatment admissions in Nevada in 2011. Data show that stimulants, including methamphetamine, are the most commonly cited drugs among primary drug treatment admissions in the state (SAMHSA TEDS, 2012).

Methamphetamine and other common drugs in Nevada: Methamphetamine (meth), an illegal stimulant, is the most frequently encountered drug in Nevada (21.5 percent of drug users) (SAMHSA TEDS, 2012) and remains available in both personal use and distribution quantities (ONDCP, 2008). According to the Rural Law Enforcement Methamphetamine Initiative, meth (classified as a stimulant or amphetamine) affects the remote and rural areas of Nevada to a greater extent due to a lack of available treatment resources in those immediate areas. Nevada’s overall rate of meth use remains higher than most states. Urban areas remain vulnerable to a high supply, while rural areas receive shipments from urban and out-of-state sources. Meth continues to be a top priority for Nevada law enforcement as the state’s rate of treatment for meth use is three times the national average. Nearly 12 percent of Nevada’s high school student population report ever using meth, and the state spends $6.75 million annually on youth who are addicted to the drug. Meth is also a factor in the cases of 40 percent of men and 72 percent of women incarcerated in Nevada (RLEMI, 2011).

Other endemic drugs in Nevada are heroin and cocaine. Mexican black tar heroin remains the most prevalent form of heroin available in the state (ONDCP, 2008). Cocaine, particularly crack...
cocaine, is a significant problem in the urban areas of Nevada. In 2011, about 8 percent of drug treatment admissions in Nevada were for heroin, 5 percent for cocaine (SAMHSA TEDS, 2012).

Substance abuse is a challenging issue for both urban and rural communities. As Nevada is primarily a rural state, there are serious implications. Rural and urban places today have similar rates of substance use and abuse, and, for abuse of some substances, rural Americans are at an even higher risk than their urban counterparts. For instance, rural youth are particularly at risk for substance abuse, and stimulant use among the unemployed is higher in rural America (Van Gundy, 2006).

**DRUGS AND WOMEN**

Women typically enter the criminal justice system for non-violent crimes that are often drug or property-related. A 2012 report by the National Resource Center on Justice Involved Women offered some interesting truths about women in the justice system. It is these truths that must be recognized to successfully manage this specific population, achieve greater reductions in recidivism, and improve public safety outcomes: 1) Women are a fast-growing criminal justice population, yet they pose a lower public safety risk than men; 2) Women follow unique pathways into crime and present risk factors that signal different intervention needs; 3) Traditional criminal justice policies and practices have largely been developed through the lens of managing men, not women; 4) Gender responsive assessment tools can enhance case management efforts with justice involved women; and 5) Incarceration and re-entry are particularly challenging for justice involved mothers of minor children (Ney et al.).

Nationwide, men typically have a much higher percentage of use in any defined drug category. For example, in 2011, about 70 percent of treatment admissions for marijuana and cocaine were male.
(versus 30 percent female) and 67 percent of admissions for heroin were male (versus 33 percent female). The trend for amphetamines\(^1\) and sedatives\(^2\) is much different. The ratio is about one-to-one for amphetamine treatment admissions (51 percent male admissions and 49 percent female admissions). Also of notable significance, females have an admission rate twice as high as males in the category of sedatives (68 percent vs. 32 percent) (SAMHSA TEDS, 2012).

**Stimulants and Women:** Methamphetamine has become the growing illicit drug of choice among young women because, among other reasons, it is affordable and readily available. In most substance abuse treatment programs, women make up more than half of the clients treated for meth. One study indicated five times the percentage of females than males attributed initial meth use to a desire to lose weight; and more females than males reported using meth to get more energy (Brecht et al., 2004).

Amphetamines (also known as stimulants) were used to treat obesity in the 1950s and 60s and are now commonly abused among dieters across America. The public’s unfavorable perception that “image is everything” exposes and entices women, through the media, to improve their physical appearance (Roehr, 2005 and UCLA, 2012). However, what separates women from these icons or false role models is that they can’t afford the luxuries that many of these women rely on (professional trainers, plastic surgery, etc.). Poverty plays a role and makes women more susceptible to drug use as an inexpensive alternative. Additionally, the seductive allure and pleasurable side effects – including loss of appetite, increased energy levels and alertness, euphoria and rush, weight loss and elevation of self-esteem – attract many women to these types of drugs. They are looking for thin bodies and high energy to sustain daily routines.

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\(^1\) The drug category includes admissions for methamphetamine and other amphetamines to include amphetamines, Benzedrine, Dexedrine, preludin, Ritalin and any other amines and related drugs

\(^2\) This drug category includes admissions for barbiturates including phenobarbital, Seconal, Nembutal and other sedatives/hypnotics such as chloral hydrate, Placidyl, Doriden, etc.
What some women may not realize is that unrealistic beauty ideals as presented in the media are frequently digitally altered thus perpetuating the constant striving to attain the thin ideals. The idea that “appearance is everything” is much stronger for women living in the United States than for men (Zones, 2005).

The complex psychosocial needs of women pose serious threats to their eventual drug recovery. When abusers abstain from stimulants, particularly meth, their appetite rebounds as their body discovers it has been fueling off itself. Among other factors, fatigue, lethargy, depression and rapid weight gain begin to set in. Food becomes the medicine for some, and often times, disordered eating behaviors, such as fasting, binge eating, vomiting, using laxatives, or engaging in excessive exercise become the “self-treatment-of-choice”.

WOMEN IN TREATMENT

Of the 2.3 million inmates in America’s prisons, more than 50 percent have a history of substance abuse and drug addiction (Recovery First). Only one in five drug-addicted prisoners received treatment while incarcerated (NIDA). For female abusers, or potential abusers, the corrections system or court-ordered programs may be the only opportunity they will have access to for either prevention programs (experimental or non-users) or intervention programs (chronic users). This educational programming is vital to many women as it may help to end the cycle of incarceration begetting incarceration.

Disordered eating behaviors often go unnoticed or unmentioned in substance abuse treatment programs, even when there is adequate evidence that such problems exist. Also problematic is that many facilities do not have counselors with the training (or certification) to make an accurate diagnosis. In any case, it is the clients’ concerns and behaviors that should prompt clinical intervention.
Cognitive behavioral therapies (CBT) are necessary to change negative thought patterns, beliefs and behaviors so symptoms can be managed. CBT is also the preferred treatment of choice to address eating disorders and substance use. Correctional and outpatient court-ordered programs provide a window of opportunity in a controlled environment for this behavioral change to take effect before individuals are released from prison, parole or probation.

THE HEALTHY STEPS TO FREEDOM PROGRAM
A team approach among allied health professionals directed at health and body image interventions appear warranted in this population. There have been few, if any, programs developed, implemented and evaluated using evidenced-based practice. HSF was created in response to the latter. While the program targets females in substance abuse treatment who find weight and body image issues related to their former drug use and subsequent recovery, it also empowers women to make healthy lifestyle changes for themselves and break the cycle of drug use, so they can better care for their children and their families. Failure to address these lifestyle and health issues can burden the health delivery system, social services, family life and the health of the individual participant and their family.

Published in 2009 by the University of Nevada Cooperative Extension, HSF augments existing substance abuse programming through the provision of health education for women and girls, especially those at high risk for use of methamphetamine, speed and other stimulants. Throughout this 12-week program, healthy lifestyle practices are taught as an alternative approach to weight loss and desire for increased energy. HSF incorporates education related to nutrition; physical activity and exercise; and other educational topics that address body image disturbances, disordered eating behaviors, and other poor lifestyle choices.
METHOD

SURVEY CONTENT
A self-administered online survey was developed by UNCE’s Exercise Physiologist Extension Specialist with a background in health-related programming for clients in substance abuse treatment. The survey content was developed utilizing knowledge gained by HSF program staff working with female clients in this specific population as well as questions and concerns of recovery treatment staff (counselors, educators, administrators, social workers, etc.). Questions in the following areas were included in the survey: a) Respondent demographics; b) Female client demographics; and c) Health and body image programming in treatment.

Respondent Demographics: Demographic questions about respondents, including gender, age, education, race and professional certifications, were solicited.

Female Client Demographics: Respondents were asked to answer questions related to their female clients’ drug history, self image, use of diet aids, weight history, physical activity and nutrition knowledge in addition to other problems women may face in recovery. For most female demographic questions, a five-item frequency scale was used (excluding the not applicable (N/A) response). Possible responses included: a significant amount (more than half); a moderate amount (many, but less than half); some; none; and I don’t know.

Health and Body Image Programming in Treatment: Questions were asked about apparent need, interest and beliefs in providing health and body image education to augment existing treatment recovery for female clients. A five-item agreement scale was also used (excluding the not applicable (N/A) response) for the health-related programming questions. Possible responses included: strongly agree; agree; disagree; strongly disagree; and I don’t know.

RECRUITMENT/SURVEY DISTRIBUTION
Once approval for this research project was obtained by the University of Nevada, Reno Institutional Review Board, potential participants were invited to complete the survey using one of three methods:
1. **Using the 2010 National Directory of Drug and Alcohol Abuse Treatment Programs, flyers with a link to the online needs assessment survey were mailed to substance abuse and mental health treatment facilities throughout Nevada (n = 64):** A letter was mailed to every substance abuse and mental health treatment facility throughout Nevada included in the 2010 National Directory of Drug and Alcohol Abuse Treatment Programs. Included in this letter was an invitation to participate in the online survey as well as the link to the survey.

2. **Emails were sent to individuals already participating in the HSF program or who had previously expressed an interest with the program (n = 60):** A pre-notice email was sent to known mental health and substance abuse recovery supervisors and administrators in Nevada (potential respondents) notifying them that the research project had been approved and that they would be receiving a follow-up email with an invitation to participate in an online survey. These same individuals were emailed again once the survey was available, inviting their participation as well as asking them to forward to any colleagues who work specifically with female clients. One week after the opening of the survey, a thank you/reminderc.follow-up recruitment email was sent to administrators and supervisors (and again they were asked to forward the information to their staff who worked with female clients). After an additional two weeks, the survey was closed and a final email was sent to supervisors and administrators thanking them for their participation, as well as a letter to forward to their staff thanking them for their participation.

3. **Using social media, a link to the survey was posted on Facebook:** A message with an invitation to participate in the online survey was posted on the “wall” of the following Facebook pages: HSF, Active Recovery, Addiction Technology Transfer Center Network, Air: Assistance in Recovery, Crossroads for Women, HOPI Substance Abuse Prevention Center, Join Together, National Institute of Mental Health, The Partnership for a Drug-Free America, Substance Abuse and Mental Health Services Administration (SAMHSA), Recovery Month, and Recovery Support Network. These messages were posted by the administrator of the UNCE HSF Facebook page each of the three weeks the survey was open.

The procedure involved completing an online survey that took approximately 10 minutes for participants to complete. As appreciation for taking the time to complete the survey, respondents
had an opportunity to enter a drawing to receive a complimentary HSF Curriculum Manual (Lindsay & Velasquez, 2009).

**Response:** Of the 124 letters and emails sent out, a total of 46 surveys were completed. The overall return rate was 37 percent (n=46/124). Although it is impossible to know how many people viewed the Facebook posting, three individuals reported they learned of the survey through this method.
FINDINGS

For purposes of this report, only data from treatment providers in Nevada were analyzed. Fifteen surveys excluded from this report came from individuals in Johannesburg (Africa) (n=1); Arkansas (n=1); California (n = 4); Florida (n = 2); Massachusetts (n=1); Missouri (n=1); New York (n=1); Utah (n = 3); and Wyoming (n=1).

Table 2: Respondent Demographics (N=46)

<table>
<thead>
<tr>
<th>Characteristic</th>
<th>n (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gender</td>
<td></td>
</tr>
<tr>
<td>Female</td>
<td>37 (80%)</td>
</tr>
<tr>
<td>Male</td>
<td>9 (20%)</td>
</tr>
<tr>
<td>Race/Ethnicity*</td>
<td></td>
</tr>
<tr>
<td>Caucasian/White</td>
<td>34 (76%)</td>
</tr>
<tr>
<td>Hisp./Latino or Mexican</td>
<td>6 (13%)</td>
</tr>
<tr>
<td>African American/Black</td>
<td>3 (7%)</td>
</tr>
<tr>
<td>Asian/Pacific Islander</td>
<td>1 (2%)</td>
</tr>
<tr>
<td>Native American</td>
<td>1 (2%)</td>
</tr>
<tr>
<td>Age</td>
<td></td>
</tr>
<tr>
<td>18-29</td>
<td>7 (15%)</td>
</tr>
<tr>
<td>30-39</td>
<td>12 (26%)</td>
</tr>
<tr>
<td>40-49</td>
<td>15 (33%)</td>
</tr>
<tr>
<td>50-59</td>
<td>9 (20%)</td>
</tr>
<tr>
<td>60-69</td>
<td>3 (7%)</td>
</tr>
<tr>
<td>Education (Highest Level)</td>
<td></td>
</tr>
<tr>
<td>Master’s Degree</td>
<td>28 (61%)</td>
</tr>
<tr>
<td>Bachelor’s Degree</td>
<td>12 (26%)</td>
</tr>
<tr>
<td>Some College/Assoc. Degree</td>
<td>4 (9%)</td>
</tr>
<tr>
<td>Post-Grad Degree</td>
<td>1 (2%)</td>
</tr>
<tr>
<td>High School</td>
<td>1 (2%)</td>
</tr>
<tr>
<td>Current Position</td>
<td></td>
</tr>
<tr>
<td>Counselor</td>
<td>25 (54%)</td>
</tr>
<tr>
<td>Supervisor</td>
<td>6 (13%)</td>
</tr>
<tr>
<td>Other**</td>
<td>5 (11%)</td>
</tr>
<tr>
<td>Director</td>
<td>4 (9%)</td>
</tr>
<tr>
<td>Educator</td>
<td>3 (7%)</td>
</tr>
<tr>
<td>Social worker</td>
<td>3 (7%)</td>
</tr>
</tbody>
</table>

* 1 respondent did not answer
**Other Responses: Coordinator/Therapist; Case Manager, Juvenile Probation Officer, Program Analyst, Recreational Therapist

Table 3: Respondent Work Demographics (N=46)

<table>
<thead>
<tr>
<th>Characteristic</th>
<th>n (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Facility Location</td>
<td></td>
</tr>
<tr>
<td>Southern Nevada</td>
<td>39 (85%)</td>
</tr>
<tr>
<td>Las Vegas = 37; Henderson = 2</td>
<td></td>
</tr>
<tr>
<td>Northern Nevada</td>
<td>7 (15%)</td>
</tr>
<tr>
<td>Reno = 5; Sparks = 1; Minden = 1</td>
<td></td>
</tr>
<tr>
<td>Facility Type</td>
<td></td>
</tr>
<tr>
<td>Substance Abuse Treatment Facility</td>
<td>33 (72%)</td>
</tr>
<tr>
<td>Government (national, state, local, etc.)</td>
<td>4 (9%)</td>
</tr>
<tr>
<td>Justice System (social worker, probation)</td>
<td>3 (7%)</td>
</tr>
<tr>
<td>Mental Health Treatment Facility</td>
<td>2 (4%)</td>
</tr>
<tr>
<td>Non Profit</td>
<td>2 (4%)</td>
</tr>
<tr>
<td>Private Practice</td>
<td>2 (4%)</td>
</tr>
<tr>
<td>Type of Care Available at Facility</td>
<td></td>
</tr>
<tr>
<td>Inpatient/Residential &amp; Outpatient</td>
<td>28 (61%)</td>
</tr>
<tr>
<td>Outpatient</td>
<td>10 (22%)</td>
</tr>
<tr>
<td>Inpatient/Residential</td>
<td>7 (15%)</td>
</tr>
<tr>
<td>Transitional Housing</td>
<td>1 (2%)</td>
</tr>
<tr>
<td>Client Population*</td>
<td></td>
</tr>
<tr>
<td>Substance Abuse – Adults</td>
<td>42 (91%)</td>
</tr>
<tr>
<td>Mental Health – Adults</td>
<td>22 (48%)</td>
</tr>
<tr>
<td>Substance Abuse – Juveniles</td>
<td>14 (30%)</td>
</tr>
<tr>
<td>Mental Health – Juveniles</td>
<td>11 (24%)</td>
</tr>
<tr>
<td>Prisoners</td>
<td>4 (9%)</td>
</tr>
<tr>
<td>Homeless</td>
<td>2 (4%)</td>
</tr>
</tbody>
</table>

*Respondents were able to give more than one response (% will not equal 100)
RESPONDENT DEMOGRAPHICS

Respondent demographics can be found in Table 2 (gender, race/ethnicity, age, highest education level, and current work position). Table 3 provides information pertaining to the facility where respondents’ work location, facility type, type of care available, and client population). Table 4 lists how respondents learned of the needs assessment survey opportunity.

<table>
<thead>
<tr>
<th>Table 4: How Respondents Found Out About Survey, (N=46)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sent an email with link</td>
</tr>
<tr>
<td>Colleague forwarded email with link</td>
</tr>
<tr>
<td>Link was posted on Facebook</td>
</tr>
<tr>
<td>Sent a letter in the mail with link</td>
</tr>
<tr>
<td>SAMHSA’s Recovery Month Website</td>
</tr>
</tbody>
</table>

FEMALE CLIENT DEMOGRAPHICS

The following questions identify respondents’ levels of agreement regarding specific programming for female clients (e.g., drug use, mental health, reasons for using, etc.):

Q1: Of the FEMALE CLIENTS I work with, ____________ are CURRENTLY IN TREATMENT FOR ABUSE of illegal stimulant-type drugs (methamphetamine, crack/cocaine, ecstasy, etc.).

- 96% report their female clients are currently in treatment for abuse of illegal stimulant-type drugs (56% report a significant amount; 24% a moderate amount; 16% some).

Q2: Of the FEMALE CLIENTS I work with, ____________ HAVE ABUSED illegal stimulant-type drugs (methamphetamine, crack/cocaine, ecstasy, etc.) IN THE PAST, though they may not be currently in treatment for substance abuse.

- 95% report their female clients have abused illegal stimulants in the past (60% report a significant amount; 14% a moderate amount; 21% some).

Q3: Of the FEMALE CLIENTS I work with, ____________ utilize (or have used in the past) over-the-counter stimulant-type products (energy pills, weight loss pills, energy drinks, etc.).

- 89% report their female clients utilize (or have used in the past) over-the-counter stimulant-type products (26% report a significant amount; 39% moderate amount; 24% some).
Q4: Of the FEMALE CLIENTS I work with, ____________ take prescription anti-depressants, anti-psychotics or other mental health medications.

- 98% report their female clients take prescription anti-depressants, anti-psychotics or other mental health medications (41% report a significant amount; 33% moderate amount; 24% some).

Q5: Of the FEMALE CLIENTS I work with, ____________ HAVE REPORTED WEIGHT GAIN since they began their recovery process (or stopped using their drug of choice).

- 94% report that their female clients disclosed having gained weight since they began their recovery process (57% report a significant amount; 23% moderate amount; 14% some) NOTE: Only 1 respondent reported not having had a client report weight gain and two respondents did not know whether their clients had.

Q6: For those who have reported weight gain in their recovery, this WEIGHT GAIN HAS NEGATIVELY IMPACTED TREATMENT (e.g., stopped taking prescribed medications, substance abuse relapse, etc.) for ____________ of them.

- 73% expressed that for those who have reported weight gain in their recovery, this weight gain has negatively impacted treatment (15% report a significant amount; 29% moderate amount; 29% some).

Q7: For those who have reported weight gain in their recovery, this WEIGHT GAIN HAS NEGATIVELY AFFECTED SELF-ESTEEM OR SELF-IMAGE for ____________ of them.

- 84% expressed that for clients who have reported weight gain in their recovery, the weight gain has negatively affected self-esteem or self image (38% report a significant amount; 22% moderate amount; 24% some).

Q8: Of the FEMALE CLIENTS I work with, ____________ reported having used stimulants for the purpose of WEIGHT LOSS (e.g., methamphetamine, cocaine, diet products, energy pills, etc.).

- 91% report their female clients disclosed having used stimulants for the purpose of weight loss (34% report a significant amount; 18% a moderate amount; 39% some).

Q9: Of the FEMALE CLIENTS I work with, ____________ reported having used stimulants for the purpose of GAINING ENERGY (e.g., methamphetamine, cocaine, diet products, energy pills, etc.).

- 84% report their female clients disclosed having used stimulants for the purpose of gaining energy (38% report a significant amount; 22% a moderate amount; 24% some).
Q10: Of the FEMALE CLIENTS I work with, ____________ report they utilize weight loss supplements or other diet aids to lose weight (e.g., pills, liquid diets, popular Hollywood diets, etc.).

- 80% report their female clients disclosed having utilized weight loss supplements or other diet aids to lose weight (e.g., pills, popular diets, etc.) (7% report a significant amount; 22% a moderate amount; 51% some).

Q11: Of the FEMALE CLIENTS I work with, ____________ report using compensatory behaviors such as binging & purging, excessive exercise, misuse of laxatives, etc. to lose weight.

- 75% report their female clients disclosed using compensatory behaviors (i.e., binging and purging, excessive exercise) to lose weight (4% report a significant amount; 7% a moderate amount; 64% some).

Q12: Of the FEMALE CLIENTS I work with, ____________ report skipping meals to lose weight.

- 75% report their female clients disclosed skipping meals to lose weight (16% report a significant amount; 16% a moderate amount; 43% some).

Q13: Of the FEMALE CLIENTS I work with, ____________ express concern about using drugs to lose weight after leaving treatment.

- 63% report their female clients express concern about using drugs to lose weight after leaving treatment (6% report a significant amount; 20% a moderate amount; 37% some).

Q14: Of the FEMALE CLIENTS I work with, ____________ express concern that taking mental health medication contributes to their weight gain.

- 80% report their female clients express concern that taking mental health medication contributes to their weight gain (16% report a significant amount; 23% a moderate amount; 41% some).

Q15: Of the FEMALE CLIENTS I work with, ____________ purposefully AVOID TAKING THEIR PRESCRIPTION MENTAL HEALTH MEDICATIONS because they believe these meds are causing weight gain.

- 64% report their female clients purposefully avoid taking their prescription mental health medications because they believe these meds are causing weight gain (11% report a significant amount; 18% a moderate amount; 35% some).
Q16: Of the FEMALE CLIENTS I work with, ____________ REQUEST SPECIFIC MENTAL HEALTH MEDICATIONS from their doctor because they believe these meds will prevent weight gain or help them lose weight.

- 42% report their female clients request specific mental health medications from their doctor because they believe these meds will prevent weight gain or help them lose weight (7% report a significant amount; 4% a moderate amount; 31% some).

Q17: Of the FEMALE CLIENTS I work with, ____________ report feelings of helplessness or powerlessness with regard to their weight or physical appearance.

- 82% report their female clients disclosed feelings of helplessness or powerlessness with regard to their weight or physical appearance (20% report a significant amount; 24% a moderate amount; 38% some).

Q18: Of the FEMALE CLIENTS I work with, ____________ report feeling unattractive due to excessive weight or physical appearance.

- 93% report their female clients disclosed feeling unattractive due to excessive weight or physical appearance (31% report a significant amount; 29% a moderate amount; 33% some).

Q19: Of the FEMALE CLIENTS I work with, ____________ allow their weight or physical appearance to isolate them socially.

- 73% report their female clients allow their weight or physical appearance to isolate them socially (9% report a significant amount; 27% a moderate amount; 37% some).

Q20: Of the FEMALE CLIENTS I work with, ____________ have adequate knowledge of how nutrition and physical activity can affect weight change.

- 80% report their female clients have adequate knowledge of how nutrition and physical activity can affect weight change (4% report a significant amount; 16% a moderate amount; 60% some).

HEALTH-RELATED PROGRAMMING

The following questions identify respondents’ levels of agreement regarding specific programming for female clients (e.g., nutrition & physical activity, weight and body image concerns):

Q23: I believe a health and body image program would benefit female clients at my facility.

- 93% believe a health and body image program would benefit female clients at their facility (65% strongly agree; 28% agree).
Q24: I believe female clients would be interested in a health and body image class at my facility.

- 92% believe female clients would be interested in a health and body image class at their facility (59% strongly agree; 33% agree).

Q26: I am interested in learning more about the health & body image program, Healthy Steps to Freedom.

- 67% report they are interested in learning more about Healthy Steps to Freedom (26% strongly agree; 41% agree).

Q29: I am interested in attending a training to learn how to facilitate the Healthy Steps to Freedom program at my facility?

- 52% report they are interested in attending a training to learn how to facilitate the Healthy Steps to Freedom program at their facility (22% strongly agree; 30% agree).

Q: Is there anything else you would like to tell us in relation to publishing or implementing a health and body image program?

Four respondents gave relevant additional information:

- As a non-profit, cost is often the prohibitive factor in implementing new programming.
- This is a very important program for women, men, and families.
- It is a good idea that your agency is providing this service to the clients at [facility]. One of the things I hear among the clients is the men are interested in this service because once they stop using drugs they tend to gain weight and some of them do ask for ways to lose or not gain weight.
- Good program

For a list of questions not included in the final analysis, see page 22.
DISCUSSION

Respondents’ answers to questions related to their female clients’ drug history, medication usage, self image, use of diet aids, weight history, and health knowledge were helpful in determining that a health and body image program continues to be useful in augmenting substance abuse and mental health recovery programs.

Results of this survey demonstrate many key findings. Above all, use of stimulants (both legal and over-the-counter) is prevalent in the female client population represented by respondents. This is an important point because as many clients discontinue use of stimulants, they tend to gain weight (Emerson et. al, 2009). Weight gain may negatively impact self-esteem and ultimately the treatment plan of many drug addicts; this, in some instances, may cause a substance abuse relapse.

Our findings were consistent with previous research (Brecht et al., 2004) regarding women and the reasons they use stimulant type drugs. We found that an astounding number of providers report female clients using stimulants for weight loss (91 percent) and energy (84 percent). Of great importance is the fact that many female clients represented in this survey report feelings of unattractiveness, helplessness or powerlessness with regard to their weight. These feelings are not only influenced by drug use, but can negatively impact the treatment plan of women as their weight continues to increase.

In substance abuse treatment, there has been an increasing emphasis on treating individuals with dual diagnoses (meaning, if a client were to be evaluated as needing both substance abuse and mental health care, every effort would be made to get the individual treated

...
properly with both). The HSF program focuses on body dissatisfaction, eating pathology, and thin-ideal internalization rather than a formal eating disorder diagnosis. Unfortunately in many communities, substance abuse programs do not have staff who can make an accurate diagnosis nor do they have the resources to refer clients. This is particularly true in Nevada where there are few eating disorder treatment facilities in the state. It is client concerns and behaviors however, that should trigger clinical intervention. These behaviors (e.g., skipping meals, using compensatory behaviors such as binging and purging or excessive exercising to lose weight) when left untreated in substance abuse treatment can escalate into more serious health problems (i.e., full-blown eating disorders). Respondents report that 75 percent of their female clients disclosed both skipping meals and using compensatory behaviors to lose weight, which is cause for great concern in this population since we know that weight issues can cause substance abuse relapse.

One area often overlooked by treatment providers is the unintended impact of mental health medications on clients. Our findings suggest that nearly all (98 percent) of the females represented in our sample currently have prescriptions for mental health medications. This is important to note because our findings suggest that women often do not take their medication as prescribed because of weight concerns. Over three-quarters (80 percent) of respondents report that their female clients express concern that mental health medications contribute to weight gain and the majority (64 percent) report they have clients who avoid taking prescribed medications because of the belief they will gain weight. Also problematic is that clients admit asking their physicians for specific mental health medications (ones that are believed not to increase weight), which could prolong or negatively impact their treatment plan.

Our findings conclude with the overall positive response for continuing to implement the HSF program. For purposes of programming, greater than three-quarters (80 percent) of respondents report that their clients would benefit from, and be interested in, a health and body image program.
respondents believe that some or none of their clients are adequately educated with regard to how nutrition and physical activity can affect weight change (60 percent claim their clients had some knowledge and 20 percent claim no knowledge in this area). More than 90 percent believe their clients would benefit from, and be interested in, a health and body image program.

Analysis of five questions were omitted from this report as answers may have been tainted by the fact that the HSF program was being administered in a given facility concurrently with the timing of this survey. Those questions were as follows:

Q21: There are currently programs in place at my facility to educate female clients about nutrition and physical activity.

Q22: There are currently programs in place at my facility to educate female clients about weight and body image concerns.

Q25: The health & body image program, Healthy Steps to Freedom, is currently being implemented at my facility.

Q27: I am interested in providing the Healthy Steps to Freedom curriculum, a health & body image program, to clients at my treatment facility.

Q28. If you are not interested, please specify why you would not consider implementation of this program at your facility.
CONCLUSION

As determined by respondents’ answers to questions related to their female clients’ drug history, medication usage, self image, use of diet aids, weight history, and health knowledge, it was determined that a health and body image program may improve substance abuse and mental health recovery programming.

The need for a male curriculum specifically mentioned by respondents is known. Although the adult curriculum was designed for female clients, most of the information can also be used in men’s groups. However, the HSF curriculum is not suggested to be presented in coed groups due to sensitive nature of some of the material (many women are not comfortable talking about their weight and weight-related issues in front of their male counterparts). With limited funding, the HSF program is only taught to adult women and juvenile girls. Counselors are invited to complete a two-day training to learn the material in order to educate male clients in Nevada as well as nationwide.

Although the majority of respondents work primarily with adults, there is a growing need to provide programming for the juvenile population as well (as seen by the fact that 30 percent of substance abuse and 24 percent of mental health professionals work directly with this specific population. As teen drug use continues to increase, especially prescription drug use (Johnston, 2012), an adolescent version of the HSF program is being developed to meet the needs of a younger female population (planned to be published in 2013).

Limitations of this Project:

1. Although the researchers would have preferred a larger sample size, there is sufficient evidence from this needs assessment to ascertain the importance of a health and body image program as a supplement to traditional substance abuse and mental health recovery treatment. About half (52 percent), reported interest in attending a training to learn how to facilitate the HSF program at their facility.
2. Indicating interest or even a need to provide a health and body image program for female clients may not necessarily translate to classes being offered at any given location; there are many factors that influence this decision (e.g., timing of class, number of clients that would benefit). This survey does, however, provide a window into the needs and interests of a specified group of substance abuse and mental health professionals.

3. Professionals who may not value health as a part of recovery may be underrepresented in this survey.

4. There was a low response rate to this survey.

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